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Respite Partnership Collaborative (RPC) Innovation Project Evaluation

Report 1

Grace Wang, Laurel Koester, Brandy Farrar, Kathryn Manson, Dierdre Gilmore, Elena Lumby, Regin Mathew

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Executive Summary

The Mental Health Services Act (MHSA)—funded by Proposition 63—was enacted in California in November 2004. MHSA funding supports five unique components: (1) Community Services and Supports, (2) Prevention and Early Intervention, (3) Workforce Education and Training, (4) Capital Facilities and Technology, and (5) Innovative Programs. Innovative programs contribute to learning by testing new approaches to inform current and future practices.

In September 2010, the Sacramento County Division of Behavioral Health Services (DBHS) initiated a community planning process to develop Sacramento County's first Innovation Project. Through community input, the Respite Partnership Collaborative (RPC) Innovation Project was created with the goal to create alternatives to hospitalization by increasing local mental health respite service options for community members experiencing a mental health crisis in Sacramento County. The project seeks to: (1) create learning opportunities on how the project is developed and administered, (2) integrate community feedback into program development and implementation, and (3) expedite the release of funds of respite services to community organizations. The RPC Innovation Project is administered by the Sierra Health Foundation: The Center for Health Program Management (the Center).

As part of the Innovation Project, an evaluation contract was awarded to American Institutes for Research (AIR) to evaluate the 5-year RPC Innovation Project. The main evaluation objectives are to assess the extent to which the RPC Innovation Project does the following:

- Promotes successful collaboration between public and private entities (i.e., DBHS and the Center) in Sacramento County.
- Demonstrates a community-driven process.
- Improves the quality and outcomes of respite services in Sacramento County.

The purpose of this annual report is to present early findings from evaluation activities conducted from June 2013 through June 2014. Evaluation methods employed include interviews, surveys, and document review, all of which are detailed in Chapter 2.

Main findings about the RPC Innovation Project include:

- Structures and processes need to be clearly defined and implemented in order to establish a new community-driven group process and enable the group's grant making.
- Considerable time is required to establish structures and processes, and to decide on how best to engage members continually. Time is required for administrative responsibilities as well as serving on committees and attending multiple monthly meetings.
- Public and private entities may have different approaches to achieving specific activities or goals. Effort is required in presenting and resolving conflicting strategies and familiarizing each other with own priorities, resources, and approaches.

As seen from the following, diverse RPC members were engaged, though it is unclear the extent to which the RPC Innovation Project was a community-driven process:

- Intentional recruitment and accommodating members regardless of background or experience can achieve considerable diversity, including a mix of lay and professional members.
- Members need to devote many hours to the RPC Innovation Project's processes and deliberations on a monthly basis. Time commitment requirements can be seen as a problem and can help explain members' minimal role on nonmeeting-related activities, including getting organizations to develop and submit proposals for funding. In addition, time commitment requirements may be a reason why hospitals and law enforcement were not successfully engaged as key stakeholder groups.
- The Center and DBHS are perceived as co-leading the RPC Innovation Project and having more influence than members. Due to this, it remains unclear the extent to which the RPC Innovation Project demonstrates a community-driven process.

The RPC Innovation Project resulted in new respite services in Sacramento County:

- The RPC Innovation Project successfully funded organizations to provide mental health respite services to varying populations.
- Cross-cutting dimensions of respite are consistent across organizations that received funding through the RPC Innovation Project. All the respite services help clients take a mental or physical break, give clients a safe physical and emotional space to spend time, support clients in not feeling alone, and prepare clients to look forward beyond the time in respite.
- Grantees have varying capabilities to study outcomes of their services. Immediate outcomes include utilization of respite services, and all grantees reported tracking utilization. Another immediate outcome is client satisfaction. This report offers client and staff perspectives on satisfaction based on AIR's interviews. Long-term outcomes include emergency department (ED) visits, psychiatric hospitalizations, and institutionalization; these were more difficult for grantees to capture.

1.0 Background

1.1 Mental Health Services Act

The Mental Health Services Act (MHSA)—funded by Proposition 63—was enacted in California in November 2004. Its purpose and intent is to:[1]

a) Define serious mental illness among children, adults, and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

b) Reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

c) Expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations.

d) Provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure.

e) Ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

MHSA funding supports five unique components: (1) Community Services and Supports, (2) Prevention and Early Intervention, (3) Workforce Education and Training, (4) Capital Facilities and Technology, and (5) Innovative Programs.

Counties must select one or more of the following Innovative Program purposes to focus on for "learning and change."[2]

- Increase access to underserved groups.
- Increase the quality of services, including creating better outcomes.
- Promote interagency collaboration.
- Increase access to services.[3]

According to the 2009 proposed guidelines for the innovation component of the county's 3-year program and expenditure plan from the California Department of Mental Health, innovation "contributes to learning rather than a primary focus on providing a service. By providing the opportunity to 'try out' new approaches that can inform current and future practices/approaches in communities, an Innovation contributes to learning…"[4]

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[1] MHSA, Section 3. Purpose and Intent. Retrieved from http://www.mhsoac.ca.gov/docs/MHSA_AsAmendedIn2012_AB1467AndOthers_010813.pdf.

[2] Enclosure 1: Mental Health Services Act proposed guidelines for the innovation component of the county's three-year program and expenditure plan. Retrieved from http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice09-02_Enclosure_1.pdf. Last accessed September 3, 2014.

[3] MHSA, Part 3.2 Innovative Programs, Section 5830 a.1-4.

[4] Enclosure 1: MHSA. Retrieved from http://www.dhcs.ca.gov/formsandpubs/Pages/MlH-InfoNotices-Archive2009.aspx. Last accessed December 31, 2013.

1.2 History of Sacramento's Innovation Project

The Innovation Plan, approved by Sacramento County's MHSA Steering Committee, supported an Innovation Project focused on crisis and alternatives to hospitalization. Crisis had been a "recurring community concern" throughout the MHSA Community planning processes.[5] At the time the Innovation Workgroup met, Sacramento County had experienced reduced funding for mental health services resulting in the closure of the Sacramento County Crisis Stabilization Unit. The closure resulted in increased emergency room visits and hospitalizations.

In September 2010, the Sacramento County Division of Behavioral Health Services (DBHS) initiated a community planning process to develop Sacramento's first Innovation Project. DBHS convened an Innovation Workgroup of 20 community members who met four times in early 2011. The public was invited to attend all meetings and had an opportunity to provide comment at the end of each meeting. Over the course of the four meetings, the Innovation Workgroup reviewed data about mental health crises in Sacramento County (e.g., suicide rates, homelessness, and hospitalizations). It developed and refined program strategies based on data, information from the MHSA planning process, and community input. The strategies eventually became the Innovation Plan (appendix A).

The Innovation Plan presents the Respite Partnership Collaborative (RPC) Innovation Project and its purposes:

> *"The essential purpose of the Sacramento County Innovation Project is to test whether a community-driven process, that includes decision making and program design, will promote stronger interagency and community collaboration. Additionally, the County seeks to learn whether this community-driven collaborative approach can lead to new partnerships that can maximize existing resources to establish a continuum of respite services that will reduce mental health crisis…The secondary purpose of this Innovation Project is to determine whether this community-driven collaborative leads to an increase in the quality of services being delivered, including achieving better outcomes… In implementing a range of respite options designed by community partners, DBHS will test whether a process unlike the traditional government process now in place will facilitate a different outcome, be more expedient, improve relationships in the community, and create greater trust between the community and the County. It will also test whether adopting a model that gives community members program choice will improve the quality of services and produce better outcomes."*

The process of selecting the Administrative Entity will be described in greater detail in future reports.

[5] County of Sacramento, California, MHSA, innovation component of the 3-year program and expenditure plan, June 21, 2011. Retrieved from http://www.sierrahealth.org/assets/Sacramento_County_INN_Plan_FFS.pdf . Last accessed September 3, 2014.

2.0 RPC Innovation Project Evaluation

Based on a competitive request for proposal process, American Institutes for Research (AIR) was selected to conduct an independent evaluation of the RPC Innovation Project. Two RPC member representatives, two DBHS representatives, and two Center representatives reviewed applications. Appendix B includes a brief overview of AIR and the evaluation team.

The main evaluation objectives are to assess the extent to which the RPC Innovation Project does the following:

- Promotes successful collaboration between public and private organizations (i.e., between DBHS and the Center) in Sacramento County.
- Demonstrates a community-driven process.
- Improves the quality and outcomes of respite services in Sacramento County.

This evaluation employed several data collection methods to address the evaluation objectives including interviews, an RPC survey, a community survey, and document review.

2.1 Interviews

We conducted key informant interviews about the RPC Innovation Project, the RPC collaborative, and respite services. In total, we conducted 24 interviews between November 2013 and July 2014 with the following groups:

- 2 people representing DBHS
- 2 people representing the Center
- 3 past RPC members
- 6 present RPC members
- 1 facilitator
- 3 community members
- 2 staff and 4 clients from Capitol Adoptive Families Alliance
- 2 staff and 3 clients from Iu-Mien Community Services
- 3 staff and 3 clients from Turning Point Community Programs, in partnership with Welcome Home Housing

All interviews were 30 to 60 minutes, in person or by phone. Interviews were audio-recorded, transcribed, and coded for themes using NVivo software. The team also analyzed detailed notes developed during interviews and consulted audio recordings for accuracy when necessary.

2.2 RPC Survey

AIR conducted an RPC survey in November and December of 2013 about the structure and processes of the RPC Innovation Project (as shown in Appendix C).[6] The RPC survey was sent electronically and via paper to 38 participants representing past RPC members, current RPC members, DBHS, the Center, and the facilitator. Each recipient received three reminders to complete the survey. Out of the 31 who completed the survey (82%), there were five RPC members who exited after the first year, 20 current RPC members, five respondents from the Center and DBHS, and one facilitator. AIR calculated descriptive statistics (e.g., means, frequencies) using Excel.

2.3 Community Survey

AIR conducted a community survey in January and February of 2014 about RPC Innovation Project awareness (as shown in Appendix D). The community survey was administered to 45 providers of adult mental health services in Sacramento County who are members of an email listserv maintained by DBHS, and to 44 Mental Health Board and MHSA Steering Committee members/alternates who are members of an email listserv maintained by DBHS. The survey was administered electronically via email listservs, and three reminders were sent. Notably, 28 out of 89 recipients (31%) completed the community survey. AIR calculated descriptive statistics (e.g., means, frequencies) using Excel.

2.4 Document Review

Each month, the Center provided AIR with the following kinds of documents, which span between 2012 to March 2014, and which have been reviewed by AIR:

- Available grant funds for specific rounds
- Conference materials
- MHSA[7] and other legal documents
- Process documents (e.g., full RPC and committee meeting notes, agendas, schedules, summaries, evaluations, and handouts)
- Proposal review documents (e.g., summary reports, review meetings, and review tools)
- Public media documents
- RPC Innovation Project history and development (e.g., Innovation Plan, Napper settlement)
- RPC Request for Proposals
- Sierra Health Foundation Scope of Services

[6] Kenney, E., & Sofaer, S. (2000). Coalition self-assessment survey. Retrieved from http://research.policyarchive.org/21651.pdf

[7] Retrieved from http://www.mhsoac.ca.gov/docs/MHSA_AsAmendedIn2012_AB1467AndOthers_010813.pdf

- Structure documents (e.g. “who’s in the room” spreadsheet, presentations on roles, and membership documents)

In addition, Round 1 grantee organizations and the Center provided AIR with documents about the following:

- Grantees’ respite program structure (e.g., grant applications)
- Processes (e.g., data collection tools)
- Progress towards achieving their respite program goals
- Scopes of work
- Site visit reports

AIR summarized or coded documents using NVivo 10 qualitative analysis software. Documents that contained redundant information were not summarized or coded. For example, AIR summarized meeting notes but did not summarize the associated meeting agenda.

3.0 Report Purpose and Sections

The purpose of this report is to present findings from evaluation activities conducted from June 2013 through June 2014 to the Division of Behavioral Health Services (DBHS), RPC members, and Sierra Health Foundation: The Center for Health Program Management (the Center).

This report presents the following sections:

- RPC Innovation Project structure and processes. This section describes the three entities (i.e., DBHS, the Center, and RPC members) involved in the RPC Innovation Project, and their responsibilities in membership, decision making, community education and awareness, sustainability, grant making, and grantee technical support.
- Dimensions of community participation in the RPC Innovation Project.
- Respite services provided by RPC grantees.
- Next steps for new data collection until evaluation completion in 2016.

4.0 RPC Innovation Project Structure and Processes

The Planning Committee (DBHS, the Center, and a facilitator) developed the initial structure and processes before RPC members were recruited and inducted. An Ad Hoc RPC Workgroup comprised of initial Innovation Workgroup members was convened to recommend and develop initial structure and processes to launch the RPC Innovation Project. Later, the Planning Committee and RPC members refined structures and processes; the following describes the status as of the writing of this report.

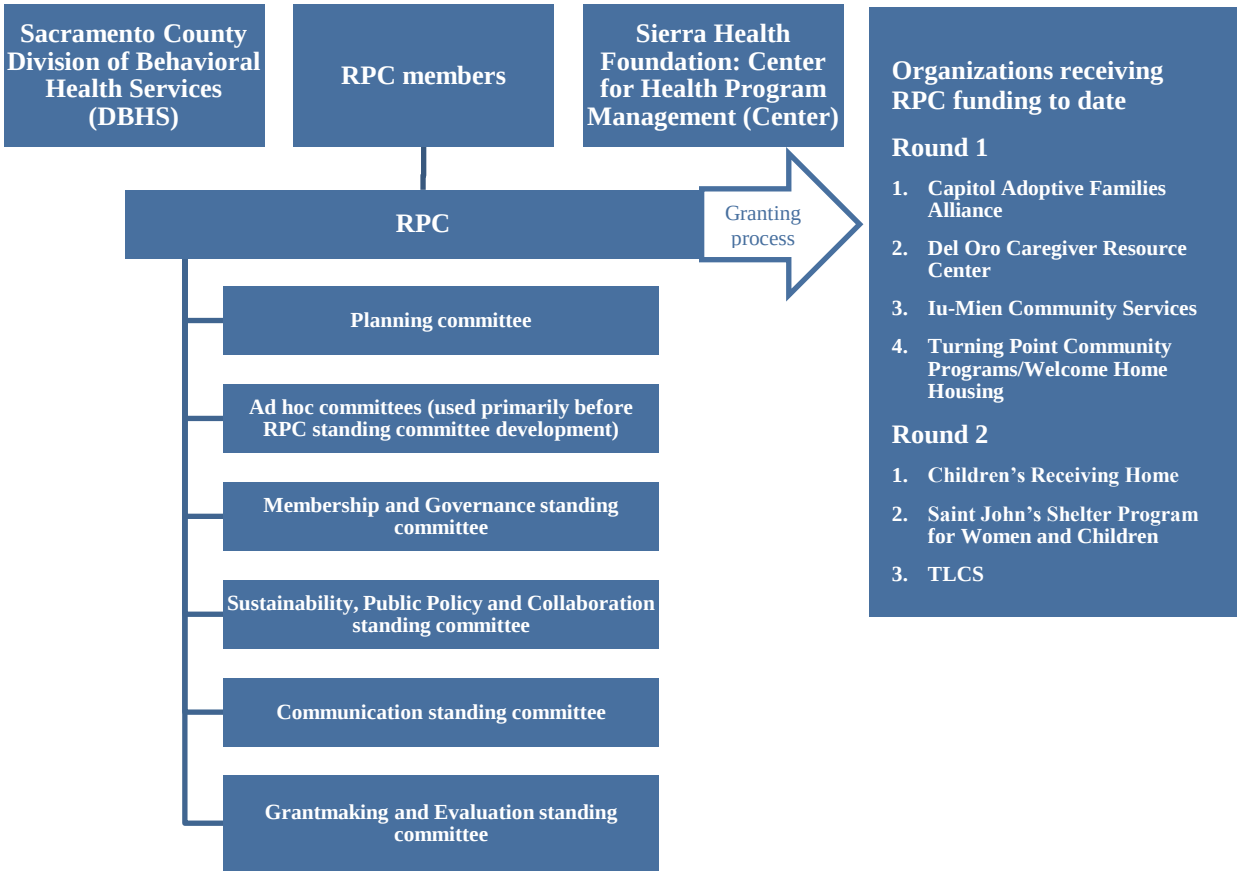
4.1 Structures

The RPC Innovation Project involves three entities:

1. Sacramento County Division of Behavioral Health Services (DBHS)—a division within Sacramento County Health and Human Services, received MHSA Innovation funding from the state to design and implement the RPC Innovation Project between July 2011 and June 2016.
2. Sierra Health Foundation: Center for Health Program Management (the Center)—an independent 501(c)(3) nonprofit in Sacramento County, administers the RPC Innovation Project using Sacramento MHSA Innovation funding through a contract from DBHS.
3. RPC members—individuals representing many stakeholder perspectives. As of December 2013, the RPC members represented adult consumers and persons with lived mental health experience, family members of adult consumers, family members of youth, mental health providers, service providers for aging or older adult, children and youth organizations, providers for child welfare or foster care, health, cultural, and ethnic communities, faith-based communities, homeless service organizations, persons with disabilities, and the lesbian, gay, bisexual, and transgender community. One RPC member seat is reserved for DBHS. Membership numbers have changed over time with 10 persons exiting their position as RPC members following the year 2012 and 12 new members joining the Collaborative for the 2013–2014 year.

All entities are responsible for being part of committees, attending committee meetings, and attending full RPC meetings (as described below in exhibit 1).

Exhibit 1. Respite Partnership Collaborative Innovation Project Structure



4.1.1 Planning Committee

Before the RPC Innovation Project had inducted RPC members, the Planning Committee set the preliminary structure and processes for the project. The Planning Committee started with DBHS, the Center, and a facilitator. RPC co-chairs were elected in the spring of 2013 based on selection criteria established by the RPC membership committee to "represent the RPC membership viewpoint during the planning meetings." RPC co-chairs collaborate with the Center and DBHS in planning the RPC meetings.

The Planning Committee meets twice a month, and meetings run from 2 to 3 hours to develop full RPC meeting goals and agendas. During more intense planning phases, especially early in the development of the RPC, the planning committee met weekly for up to 4 hours.

4.1.2 Ad Hoc Committees

Three ad hoc committees were developed between July 2012 and November 2012 as interim entities. Ad hoc committees were formed by RPC member volunteers. These three committees accomplished the following:

- Established structure. An Ad Hoc Governance and Membership Committee developed recommendations on RPC membership policies and governance structure, which included co-chairs as described above.
- Reviewed narrative sections of the Round 1 draft Developing and Releasing the Request for Proposals (RFP).
- Reviewed proposals for the external evaluation.
- Reviewed proposals to complete funding recommendations for Round 1 grantees.

4.1.3 Standing Committees

RPC members serve on a committee and participate in one to two standing committee meetings per month that last 2 to 4 hours per month (exhibit 2). As of the writing of this report, the Membership and Governance Committee and the Grantmaking and Evaluation Committee have chairs who do the following:

- Coordinate meeting times, dates, and locations based on committee needs with Center staff.
- Partner with Center staff to set meeting goals and develop meeting agendas.
- Facilitate committee meetings in partnership with Center staff.
- Provide updates to Center staff.
- Provide a written summary for committee use and documentation when Center staff is unavailable to take notes.
- Report back to RPC on committee activities on a regular basis with support from Center staff.

In addition, the DBHS Contracts Monitor provides technical assistance to all committees as needed. Center staff partner with committee chairs to create committee agendas and take notes.

Exhibit 2. Standing Committees

Committee	Committee's Charge, as Described in the 2013 RPC Charter	Membership and Attendance* (March 2013 to April 2014)
Governance and Membership	▪ Review RPC governance issues and provide recommendations to be brought forth to the RPC. ▪ Oversee membership recruitment including soliciting and reviewing applications, selecting new members and developing a process for orienting new RPC members. ▪ Identify missing member stakeholder perspectives on the RPC and actively recruit those stakeholders as RPC members. ▪ Consider special requests/exceptions with respect to appointing alternates and oversee membership rules. ▪ Work with partners to identify ways to facilitate participation of members via technology.	▪ Average 5 members ▪ 15 meetings ▪ Average 85% meeting attendance

Committee	Committee's Charge, as Described in the 2013 RPC Charter	Membership and Attendance* (March 2013 to April 2014)
Grantmaking and Evaluation	▪ Develop Requests for Proposals following the guidelines agreed to by the RPC. ▪ Review submitted proposals and present selected proposals to the RPC for final recommendation to the Center and DBHS for vetting. ▪ Work with the Center and DBHS to take questions raised by the RPC back to the candidates for resolution. ▪ Communicate with internal and external evaluators. ▪ Work with the Center and external evaluators on grantee evaluation activities. ▪ Establish protocol for working with grantees to maximize the success of their projects. ▪ Develop technology to identify and track respite options in Sacramento County.	▪ Average 5 members ▪ 14 meetings ▪ Average 68% meeting attendance
Communication	▪ Develop and implement a marketing and communication plan, including the use of social media. The plan(s) will include specific approaches to reach the groups identified in the MSHA Innovation Plan as well as the larger Sacramento community. ▪ Develop and implement a communications strategy that will take a multi-pronged approach in order to promote the concept of respite throughout Sacramento County, the RPC and the public-private partnership, and respite services funded through the MHSA Innovation project. ▪ In conjunction with the Governance and Membership Committee, plan events to present selected proposals to the community.	▪ Average 4 members ▪ 2 meetings ▪ Average 38% meeting attendance
Sustainability, Public Policy, and Collaboration	▪ Create a sustainability plan that includes a strong public policy approach. ▪ Strengthen collaboration with traditional partners and establish connections with non-traditional partners. ▪ Establish partnership and networking opportunities with other community resources and MHSA programs. ▪ Engage RPC members in the implementation of the sustainability plan to ensure that the RPC can continue its work beyond the initial funding period. ▪ Identify potential funding and leveraging opportunities. ▪ Work in collaboration with RPC partners to plan and host community stakeholder meetings.	▪ Average 4 members ▪ 7 meetings ▪ Average 65% meeting attendance

*Based on available documents; attendance lists missing for some meetings.

4.1.4 Full RPC Meetings

The three entities take part in full RPC meetings, which are held monthly for 3.5 hours at the Sierra Health Foundation offices (dinner is served at evening meetings). Though a professional facilitator runs the meeting, DBHS, the Center, and RPC members often present information, updates, and recommendations. Between May 2012 and March 2014, meeting attendance ranged from 38 percent to 95 percent, with an average of 76 percent.

4.1.5 Entity-Specific Responsibilities

In addition to committees and full meetings, each entity has distinct responsibilities that were outlined in the Innovation Plan (exhibit 3).

Exhibit 3. Responsibilities Outlined in the Innovation Plan

Sacramento County Division of Behavioral Health Services (DBHS)	RPC Members	Administrative Entity
▪ Coordinate/partner with the Center to implement Innovation Plan ▪ Develop criteria for RPC membership based on Innovation Plan ▪ Provide liaison and Technical Assistance to the Center and RPC members and facilitate connections to other MHSA programs ▪ Participate as a RPC member ▪ Partner with the Center to develop evaluation framework ▪ Monitor contract with the Center ▪ Report results to Department of Mental Health and Oversight and Accountability Commission	▪ Make recommendations about RPC membership and governance structure ▪ Participate in regular RPC meetings and community stakeholder meetings ▪ Establish partnership and networking opportunities with other community resources and MHSA programs ▪ Explore options for leveraging and sustainability ▪ Participate in respite program selection process ▪ Participate in project evaluation	▪ Coordinate and partner with DBHS to implement Innovation Plan ▪ Establish RPC Innovation Project ▪ Host/coordinate and participate in full RPC and community meetings ▪ Facilitate respite program selection process ▪ Oversee and manage funding awards ▪ Develop and implement evaluation activities to assess progress on learning goals, provide data to RPC members, DBHS, and community ▪ Develop and implement communication plan (to engage community, share learning)

4.2 Processes

We describe below key processes (i.e., membership, decision making, community education and awareness, sustainability, grant making, and grantee technical support), how DBHS and the Center collaborated on the processes, and how RPC members contributed to processes.

4.2.1 Membership

The Ad Hoc Innovation Workgroup, the Center, and DBHS established a process to recruit and select the first 2012 RPC member cohort. Later, Ad Hoc and Governance and Membership Committees adopted similar processes for subsequent RPC member cohorts.

During early planning meetings, the Center and DBHS reviewed a list of stakeholder groups identified in the Innovation plan and MHSA guidelines and used these groups as a basis for recruiting the first RPC members. Strategies for recruiting members included identifying and contacting promising organizations, and attending MHSA Steering Committee and Mental Health Board meetings to announce the application process.

In addition to recruiting members, the Center and DBHS formed an RPC Member Selection Committee with volunteers from the Innovation Workgroup and system partners. The Selection Committee provided advice on the application, reviewed applications, and participated in the selection of members. The RPC Innovation Project encouraged applications from many stakeholders. Upon receipt of applications, each application was reviewed and scored by five reviewer teams who represented:

- DBHS
- Adult consumer, family member, or family member of children with serious emotional disorders (SED)
- Service provider
- Systems partner
- Other agencies

The selection process followed criteria set by the Ad Hoc Innovation Workgroup. Review team scores were averaged to determine an overall rating, and applications with low scores (grade C) were excluded immediately. Then, the Center and DBHS discussed the remaining applicants and considered their lived mental health experience, MHSA experience, connection to or representation of stakeholder groups, recommendation letters, and conflicts of interest. Based on scores, criteria, and discussion, the Center and DBHS made final RPC membership decisions for the initial cohort.

The Center and DBHS selected diverse individuals for the first cohort of RPC members. Selection was based on (1) principles in the MHSA and Innovation Plan, and (2) DBHS' practice of valuing the voice of consumers and family members with lived experience by ensuring that half of the seats are designated for these stakeholders. Reviewers considered the balance of consumers and family members with lived experience to those with other perspectives during the selection process. Additionally, the selection process ranked RPC candidates on demographics, stakeholder perspective, and a number of other characteristics. As a result, the first cohort included RPC members representing 13 different perspectives (as shown by Exhibit 5).

The Center and DBHS decided to explore membership gaps with RPC members at the first full RPC meeting. According to the RPC meeting summary from May 14, 2012, many RPC members expressed concerns about perspectives that were still not represented in the group (e.g., law

enforcement, transition-age youth). Some RPC members found it difficult to plan or decide for populations whose voices were not present in meetings. While all RPC members seemed to recognize the importance of including missing voices, some RPC members wanted to recruit new members while others wanted to move forward as soon as possible in releasing funds for services. After discussing a range of perspectives, the group reached a consensus to wait until January 2013 to recruit new members.

By December 2012, the Ad Hoc Governance and Membership Committee had formed and began analyzing and addressing recruitment and membership for the second RPC member cohort. RPC members recruited new members to participate by contacting colleagues and peers representing transition-age youth, the lesbian, gay, bisexual, transgender, and queer community, homeless service providers, cultural communities, and caregivers. The committee simplified the application but requested applicants to submit references and attend a two-hour orientation to help them understand the requirements, benefits, and impact of membership. In May 2013, 12 members renewed their memberships for 2013 and 2014, and the RPC Innovation Project welcomed 10 new RPC members (as shown in exhibit 4).

Exhibit 4. Primary Stakeholder Perspectives Represented by the 2012 and 2013 RPC Member Cohorts

Primary Stakeholder Perspectives	2012 Cohort	2013 Cohort
Adult Consumer	X	X
Aging/Older Adult Service Provider	X	X
Child Welfare / Foster Care	X	X
Cultural/Ethnic Community	X	X
Faith-Based	X	X
Family Member of Adult Consumer	X	X
Family Member of SED Child	X	
Health	X	X
Homeless Service Organization / Lived Homeless Experience	X	X
Hospital Council	X	
Nontraditional Mental Health Provider		X
Organization Serving Children & Youth	X	X
Persons with Disability and Organizations		X
Transition-Age Youth Consumer and Organizations		X

4.2.2 Decision Making

The Ad Hoc Innovation Workgroup established consensus decision making for the RPC Innovation Project. The Innovation Workgroup originally used a consensus approach during the RPC Innovation Project planning process. As the Center, DBHS, and facilitator prepared for the

first RPC meeting, it was decided to continue consensus decision making as a starting point to enable RPC members to work together. RPC members agreed to this process at the first RPC meeting and decided to revisit governance and structure, as needed, after January 2013.

Later, RPC members adopted consensus decision making for themselves. By February 2013, the Ad Hoc Governance and Membership Committee recommended for consensus as the fundamental principle in decision making (See also, Appendix E. RPC Charter):

> *"Working toward consensus is a fundamental principle of the RPC, based on principles of 'consensus with accountability.' Consensus with accountability requires all participants to try to reach consensus while at the same time supporting and expressing their stakeholder group's interest. Working toward consensus is a collaborative process with everyone contributing to shape a proposal into a decision that meets the concerns of all group members as much as possible."*

The Levels of Agreement tool assists with consensus building among RPC members. Options one through five constitute consensus; only option six represents a divergent opinion (as shown in exhibit 5). When consensus is not reached, a proposal or recommendation can only move forward if supported by 75 percent of the members present. Alternatively, if time allows, members may delegate the issue to a standing or ad hoc committee for further deliberation, information gathering, and problem-solving. RPC members must be in attendance at a meeting to participate in decisions made at that meeting.

Exhibit 5. Levels of Agreement Tool

1. Strong Agreement—I support the proposal.
2. Agreement With Minor Concern—Basically, I support the proposal.
3. Agreement With Reservations—I can live with it.
4. Stand Aside—I don't like this, but I don't want to hold up the group.
5. Disagreement With Major Concern—I don't want to stop the proposal, but I have serious concerns.
6. Strong Disagreement—I do not support this proposal.

Note: this tool can be used to deliberate proposals, recommendations, and other decisions. The italicized language is adapted for each decision.

Finally, the ad hoc committee provided guidance on administrative decisions and committee decisions. The final decisions were approved by the RPC members and documented in the RPC Charter, which describes RPC Innovation Project structures and processes (as seen in Appendix E). Simple majority can decide administrative decisions, such as meeting scheduling or an agenda item. Committees may make decisions relevant to the responsibilities of their scope of work but may not override the decisions and guidance of the entire RPC.

4.2.3 Community Education and Awareness

DBHS and the Center work together to increase community awareness of the RPC Innovation Project. They have sponsored biannual stakeholder meetings held at the Sierra Health Foundation offices with goals to educate the community about respite and to conduct outreach to

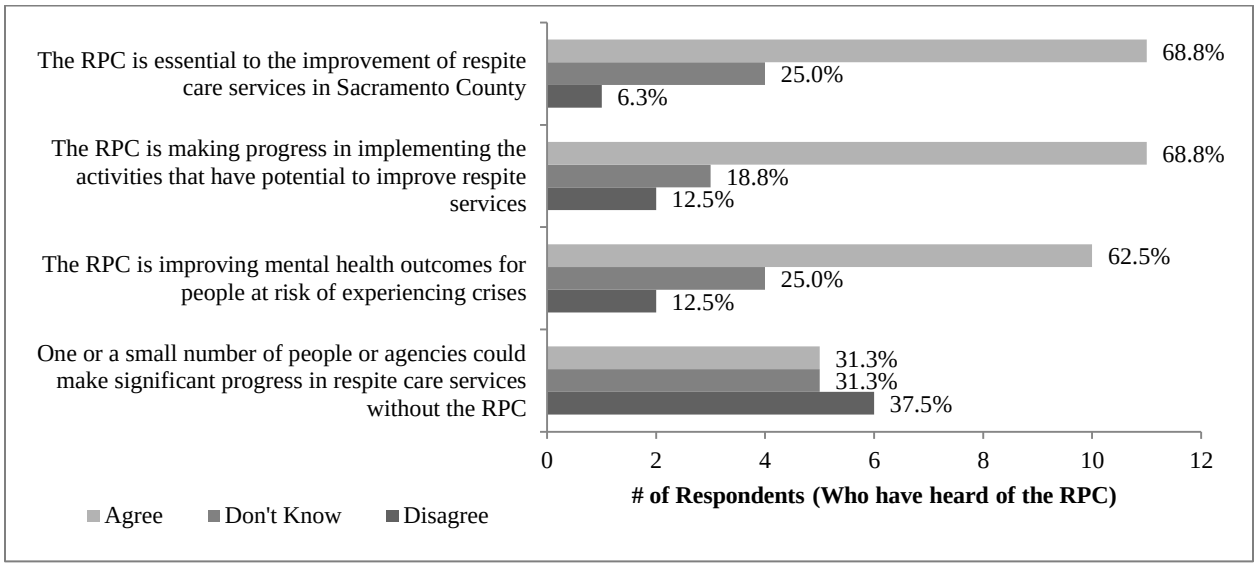
key stakeholder groups. Education events addressed stressors, availability of respite services, respite definitions, need for respite services, and the services offered by RPC grantees.

Second, the Center has posted materials such as meeting agendas, notes, and materials to the Sierra Health Foundation's website so that community members can read about the RPC Innovation Project's activities and decisions. Examples of publicly posted materials include the list of current RPC members, schedules, agendas, notes and presentations, and summaries of reports submitted by the organizations that were funded through the RPC Innovation Project. By reviewing the meeting materials, a community member is able to read about both consensus as well as dissenting views underlying decisions. At the same time, care is taken not to jeopardize confidentiality by calling out specific RPC members' comments.

Third, RPC meetings are open to the public, and community members may participate in committee meetings and full RPC meetings. During planning committee meetings in February 2012, the Center and DBHS grappled with whether to make meetings open to the public with time allotted for public comment, like past Innovation Workgroup meetings. In the interests of transparency and accessibility, the RPC meetings are open to the public, however guests are asked to register in advance to ensure that sufficient materials are available.

Findings from the community survey indicate that those who were familiar with the RPC believe the RPC has had positive effects on respite services in Sacramento County (exhibit 6). The majority (60%) of those who had heard of the RPC also reported that programs and activities may have not occurred had the RPC not been established.

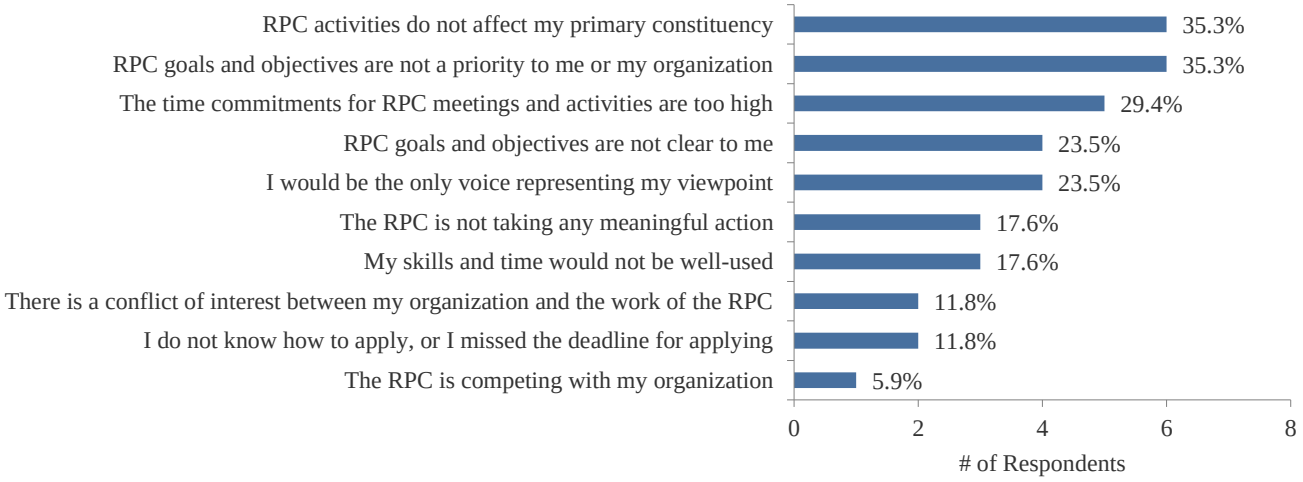
Exhibit 6. Effects of the RPC Innovation Project on Respite Services, Among Those Aware of the RPC Innovation Project*



*Does not add to the total number that completed the community survey (n=28) because this figure omits those who were not aware of the RPC or who skipped these items.

Despite awareness and viewpoints about the RPC Innovation Project's community impact, a number of factors contributed to community members' lack of participation in the RPC Innovation Project. (exhibit 7)

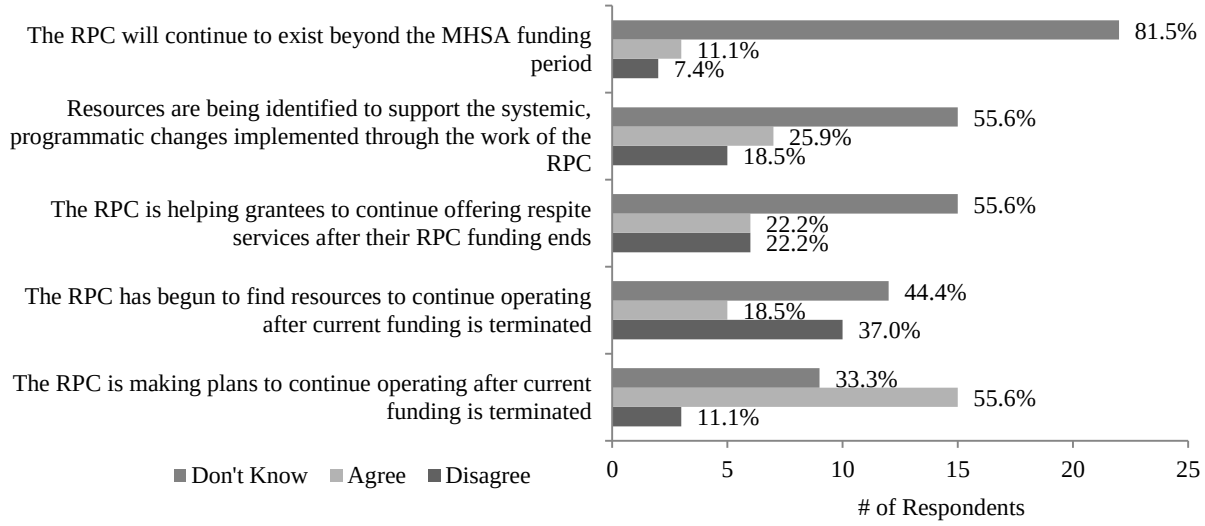
Exhibit 7. Factors That Explain the Lack of Participation in the RPC Innovation Project, Among Those Aware of the RPC Innovation Project



4.2.4 Sustainability

The Center and DBHS considered funding and sustainability with the Sustainability, Public Policy and Collaboration Committee. During the initial stages of the RPC Innovation Project, many expressed uncertainty about RPC Innovation Project sustainability (exhibit 8).

Exhibit 8. Number of Respondents to the RPC Survey Reporting Agreement to Statements About Sustainability, December 2013 *



*Does not add to the total number who completed the survey (n=31) because we omit those who skipped items or marked "not applicable"

In considering RPC Innovation Project sustainability, interviewees raised questions about their purpose in the future:

> *"…do we act then as an advisory board to the programs that are already funded? …to the county, DBHS, or to the state, Department of Healthcare Services? Do we have that kind of clout? You know, do we want to form initiatives…to promote respite, but if we don't have funding, how are we going to do that? …we have to have a purpose and what's the purpose. I would love to see us continue, but we need to all agree on the purpose…"*

RPC members also realized they, as a volunteer group, would need paid staff to facilitate their work. However, it was unclear who held responsibility for finding funding for staff. One viewpoint was that RPC members should "step up" to find resources as part of sustainability. Another viewpoint was that Sierra Health Foundation should be responsible for finding money.

The Sustainability, Public Policy and Collaboration Committee went through a strategic roles assessment exercise and a prototyping community solutions exercise to explore what it means for the RPC members to provide strategic leadership in Sacramento County around respite services. In addition, they framed a discussion about role, value, and options with the RPC members during a full RPC meeting. The committee concluded that the collaborative was not to be a funding organization.

4.2.5 Grant making and Grantee Support

DBHS and the Center collaborated on a key activity of providing grants to community organizations and supporting grantees in their work. The overall granting process involved five key activities: (1) learning about granting; (2) building consensus around key decision points; (3) developing and releasing the RFPs; (4) reviewing and selecting applications; and (5) grant monitoring. The Center's RFP release, review, and award management processes were adapted, and The Center, DBHS, and Grantmaking and Evaluation Committee made recommendations to all RPC members to deliberate until they reached consensus on which grantees to fund. We further describe this process below.

Learning about granting. The Center and DBHS worked together to offer RPC members opportunities to learn about grant making and to build skills during full RPC meetings over the course of the Round 1 and Round 2 grant cycles. For example, DBHS presented an overview of respite programs, practices and policies in June 2012 to provide everyone with a common understanding of models for providing respite, possibilities for how to fund respite services, the limited evidence on definitions of and best practices for respite, and the magnitude of the need for respite. RPC members also learned about the Request for Proposal (RFP) and Request for Qualifications (RFQ) processes so all could become familiar with granting strategies. As a result of these opportunities, RPC members built a common foundation and a common set of resources to draw on when considering how they should focus funding efforts.

Building consensus around key decision points. The Center and DBHS laid out an early objective for RPC members to build consensus around key decision points related to the grants to be awarded that built on the Innovation Plan's framework for grant making activities. Decision

point examples include: the number of awards, amount of funding per award, length of award and frequency of payment, kinds of organizations to fund, and specific kinds of programs/target populations to serve. To kick off the consensus-building process around grant making, a consensus workshop was held to elicit RPC members' perspectives and priorities. This workshop was followed by a series of RPC meetings that built on these early insights and perspectives and refined the grant making approach.

Several other strategies were used to build consensus on how to distribute the funds available for Round 1 and Round 2 grants. During full RPC meetings, RPC members worked in small groups to identify and discuss funding priorities and potential challenges; the full group then considered issues raised in small-group discussions. RPC members also used worksheets to compare different funding scenarios. Guests from the general public were invited to comment and to provide input into funding considerations during these full RPC meetings. After several meetings, RPC members reached consensus on key decisions defining the Round 1 and Round 2 requests for proposals. Examples of key decisions include: maximum and minimum funding amounts that would be considered; priority respite areas of interest (e.g., 24/7 care); and priority populations of interest (e.g., transitional aged youth, unserved or underserved cultural populations).

Developing and releasing the Request for Proposals (RFPs). The RPC Innovation Project supported development of RFPs to fund local community organizations to provide respite services. In Round 1, the Center and DBHS and a RPC ad-hoc committee developed draft RFPs that the RPC members reviewed, discussed and refined over full RPC meetings until a consensus was reached on the final RFP.

Experience from the round 1 RFP process helped to improve round 2. One interviewee suggested that building infrastructure at the same time as developing and executing the Round 1 RFP hindered the initial RFP:

> *"…we realized after the first RFP was released…we weren't seeing the kinds of proposals that we had wanted, … the initial RFP release was a little bit rushed."*

Some RPC members realized that they needed to be clearer in defining RFP objectives and respite. The Center, DBHS, and now the Grantmaking and Evaluation Committee shaped and refined the Round 2 RFP and presented it to all RPC members for discussion and consensus approval. As a result of this effort, RPC members reported that the Round 2 RFP was "better written" and "more precise".

Reviewing and selecting application. For the Round 1 RFP process, the Center selected an External Proposal Review Committee, including identified seats for consumers and family members with lived experience. The External Proposal Review Committee comprised of RPC members and community stakeholders representing consumers and family members, cultural community representatives, mental health providers, and system partners was established to review and rate the grantee proposals. Potential review committee members were identified through a nomination process (including self-nominations).

In order to be eligible, review committee participants were required to:

- Have time to read and rate proposals
- Participate in a reviewer orientation call and reviewer meetings
- Be free of a real or perceived conflict of interest
- Have knowledge of local resources, mental health, and respite care

The External review committee and an Internal Proposal Review Committee comprised of DBHS and the Center review applications for funding and rate them using a proposal rating worksheet that DBHS and the Center created. Three people review and rate each proposal. Each section is allotted a certain number of points and the points are then converted into a rating scale of 1 to 5. Each proposal receives an Internal Average Rating and External Average Rating. Review teams then select a subset of the top rated proposals for presentation to all RPC members.

The Round 2 process shifted. A Round 2 Review Team of the Grantmaking and Evaluation committee and community stakeholders with content expertise related to the funding opportunity reviewed proposals. Reviewers read all submitted proposals and used an updated review tool. The review team continued to select a subset of the top rated proposals for presentation to all RPC members.

RPC members take part in a proposal review meeting, but the meeting is closed to the general public and to RPC members with conflicts of interest. RPC members voice questions and concerns about the proposals and discuss strengths, weaknesses and alignment with the review criteria. At the end of the meeting, RPC members vote: 1) to recommend funding applicants that satisfactorily addressed the concerns identified in the meeting and 2) to trust the external and internal review committees to determine if applicants addressed concerns.

The granting process resulted in grants to four organizations during Round 1 and three organizations during Round 2 (exhibit 9).

Exhibit 9. Organizations Funded as a Result of the Granting Process

Round 1 grantees	Round 2 grantees
▪ Capitol Adoptive Families Alliance ▪ Del Oro Caregiver Resource Center ▪ Iu-Mien Community Services ▪ Turning Point Community Programs, in partnership with Welcome Home Housing	▪ Children's Receiving Home ▪ Saint John's Shelter Program for Real Change ▪ Transitional Living Community Support

Monitoring grants and building grantee capacity. A grant monitoring process, overseen by the Center and the Grantmaking and Evaluation Committee, tracks grantees' progress on performance goals and supports decisions about the release of additional RPC funding. The Center acts as an intermediary with grantees throughout the monitoring process. First, all grantees submit progress reports and annual reports to the Center documenting their progress toward performance goals and milestones. Grantees must show that they are achieving

performance goals and milestones or addressing barriers to goals and milestones before the Center releases funds to grantees. The reports are first reviewed by the Center and the Grantmaking and Evaluation Committee who recommend whether or not to approve the report. The Grantmaking and Evaluation Committee then presents the recommendation to all RPC members for a consensus vote. A vote to accept the report triggers the release of funds to grantees.

Second, grantees participate in site visits. The first site visits with Round 1 grantees in January 2014 involved a visit by Center staff who then develops a Site Visit Report and recommends Site Visit Report approval. The Grantmaking and Evaluation Committee presents the Site Visit Reports and corresponding recommendations to the full RPC for a consensus vote.

As directed by the Innovation Plan, the Center convened Grantee Learning Community events for grantees to meet and to learn from one another. For Round 1 and Round 2 grantees, there were five grantee learning community meetings between January 2013 and June 2014. The average attendance was 16 attendees representing the Round 1 and 2 Grantee organizations; RPC members; and The Center and DBHS. Grantees present on the activities that they have put into practice, challenges they have faced, and strategies for overcoming challenges. In meeting evaluations, learning community attendees agreed that they would be able to apply the information that they learned to develop and improve their respite services. Further, learning about other grantees' respite services was helpful, and the events supported grantees' ability to provide respite services. Several attendees voiced desire for more dialogue between grantees to share challenges/successes and "nuts and bolts" information.

4.3 Discussion

AIR makes two observations based on the early experiences of implementing the Innovation Project. First, a number of structures and processes must be defined and implemented in order to establish a new group and enable the group's grant making. For the RPC Innovation Project, the three entities (i.e., DBHS, the Center, and RPC members) each had responsibilities to serve on committees and to attend a variety of monthly meetings. The entities also developed many detailed processes for membership, decision making, community education and awareness, and sustainability for implementing the RPC Innovation Project. The entities not only spent time on processes that helped them to operate, but they also worked together on multiple rounds of grant making resulting in funding to seven community organizations to provide respite services. The Center and DBHS, in particular, dedicated considerable time to the extensive details required to establish these processes. As a result, the first RPC members moved as quickly as possible into making decisions.

Second, each structure and process offered entities opportunities to collaborate, but collaboration between entities that take different approaches can be challenging. Public and private entities struggled with different approaches to achieve specific activities or goals. Much of the collaboration between the Center and DBHS involved planning how the RPC Innovation Project would progress and deciding how best to engage RPC members. These two partners preferred strategies that conflicted at times, but they were still able to move forward with a set of concrete steps despite the differences in opinion.

Some key informants perceived these kinds of differences in opinion as opportunities to learn about different organizational cultures. In presenting and resolving conflicting strategies, the Center and DBHS became more familiar with each other's' priorities, resources, and approaches. One interviewee noted:

> *"They're really two different cultures, the culture within the county government and the culture within the private, non-profit sector. And so I think we're trying to just really understand each other's culture and resources and limitations and processes."*

Although the Innovation Plan outlined responsibilities, these public and private entities interpreted responsibilities differently. Defining expectations for roles and responsibilities as concretely and clearly as possible during a planning phase may help to moderate challenges that arise as part of the collaborative process.

Additional interviews about the collaboration between the public and private entities were conducted in July 2014 and will be discussed in subsequent reports.

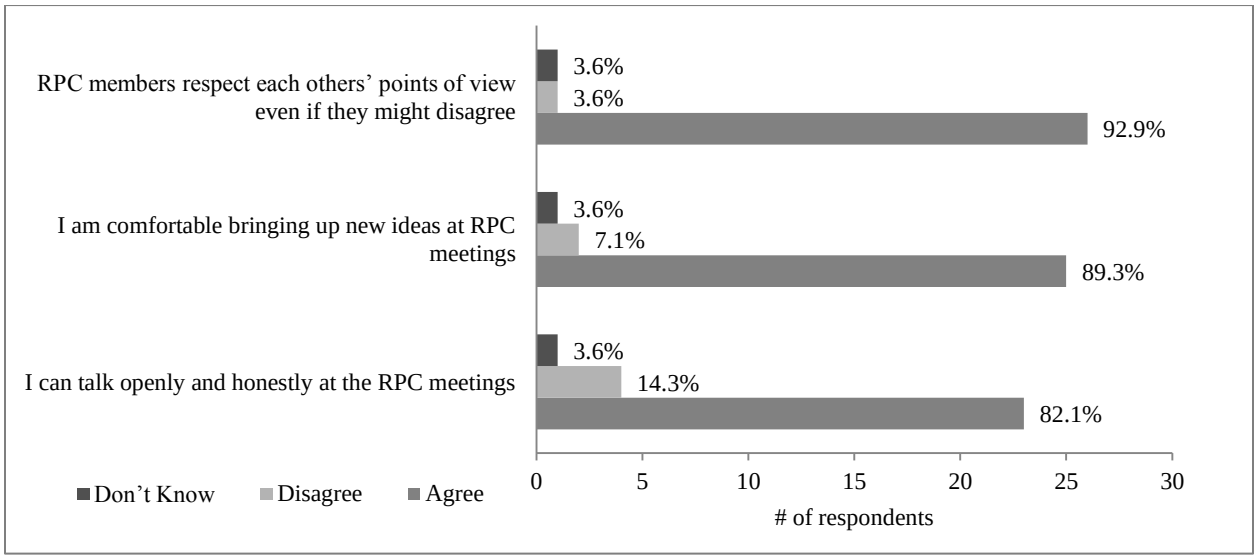
5.0 Dimensions of Community Participation in the RPC Innovation Project

To evaluate the extent to which the RPC Innovation Project demonstrates community driven processes, we analyze perceptions about collaboration, diversity of participants, amount of time spent in activities, and balance of power and leadership. These dimensions have been used frequently to assess community participation in a variety of contexts.[8]

5.1 Collaboration

Through the RPC survey conducted in December 2013, we learned that the RPC Innovation Project was perceived as being collaborative among respondents. Most survey respondents (26 out of 28) indicated that they agreed or strongly agreed that DBHS, the Center, and RPC members work collaboratively. RPC survey data also indicated that most respondents perceived a culture of openness and respect within the RPC (exhibit 10).

Exhibit 10. Openness and Respect in RPC Meetings, by Number of Respondents, December 2013*



*Does not add to the total number who completed the survey (n=31) because we omit those who skipped items or marked "not applicable". Percentages may not round to 100% because of rounding.

Interview discussions mirrored the survey data. For example one RPC member shared:

> *"For those who say, nay, we are given the opportunity to say why you feel that way. Often those nays turn to a maybe. And then that maybe, which is the process that we decided on early on, those maybes are asked, 'Can you live with this?' And it's respective of what we said. You're actually heard…"*

[8] Butterfoss, F. (2006). Process evaluation for community participation. *Annual Review of Public Health, 27*, 323–340.

Although the majority felt that they could talk openly and bring up ideas in a respectful environment, a few interviewees did note that some voices were "*…not valued at times."* For example, one key informant indicated that she did not view the relationship between the entities as equal because the RPC members did not play a large enough role in the Innovation Project planning and management.

5.2 Diversity of Participants

5.2.1 Diversity of Stakeholder Perspectives

The RPC Innovation Project, by design, included individuals representing many different stakeholder perspectives. However, certain stakeholder perspectives have proven especially difficult to engage despite recruitment efforts targeted towards these groups. Key informants identified law enforcement, transition aged youth, lesbian, bisexual, transgender, queer, and hospital emergency room and crisis response perspectives as "missing voices." Further, half of the 19 respondents to the community survey who had heard of the RPC Innovation Project, did not know if the RPC had sufficient representation from stakeholders to accomplish its objectives.

RPC members offered recommendations to raise community awareness and community engagement with the RPC Innovation Project. One recommendation was that information about the RPC Innovation Project should refer to the RPC Innovation Project and RPC members more prominently than the Center or DBHS. A second recommendation from an interviewee was that the RPC partners could collaborate more effectively on communications:

> *"…it could be improved by us, the whole project, meaning the county, the Center, the membership body, we could do a lot more around creating more visibility and awareness about respite, its role, and this opportunity and this group, this membership body that's working on it. So I think we could create more awareness and visibility through communication methods and going out and talking to people."*

5.2.2 Diversity of RPC Member Backgrounds

The stakeholders represented in the RPC Innovation Project have varying perspectives, experience, and expertise with respite services and with grant making. Some RPC members work as staff members and leaders of community organizations. Per DBHS' practice of valuing the voice of consumers and family members with lived experience, half of the Innovation Project seats are designated for these stakeholders. To meet the diverse information needs of RPC members, educational opportunities have been integrated throughout core activities along with time to build a shared understanding and consensus on decisions (see also 5.3 "Amount of time spent in activities").

5.3 Amount of Time Spent in Activities

The RPC Innovation Project requires a considerable time commitment from all RPC partners to maintain operations, to accomplish its grant making goals, and to accommodate the diverse experiences of RPC members.

A typical RPC member may spend well over eight volunteer hours per month attending committee and full RPC meetings, doing homework in preparation for meetings (e.g., worksheets about funding options, reviewing committee documents), and participating in RPC-sponsored community events (e.g., proposers' conference). One interviewee felt that these expectations were not always clearly communicated and explained absences from meetings:

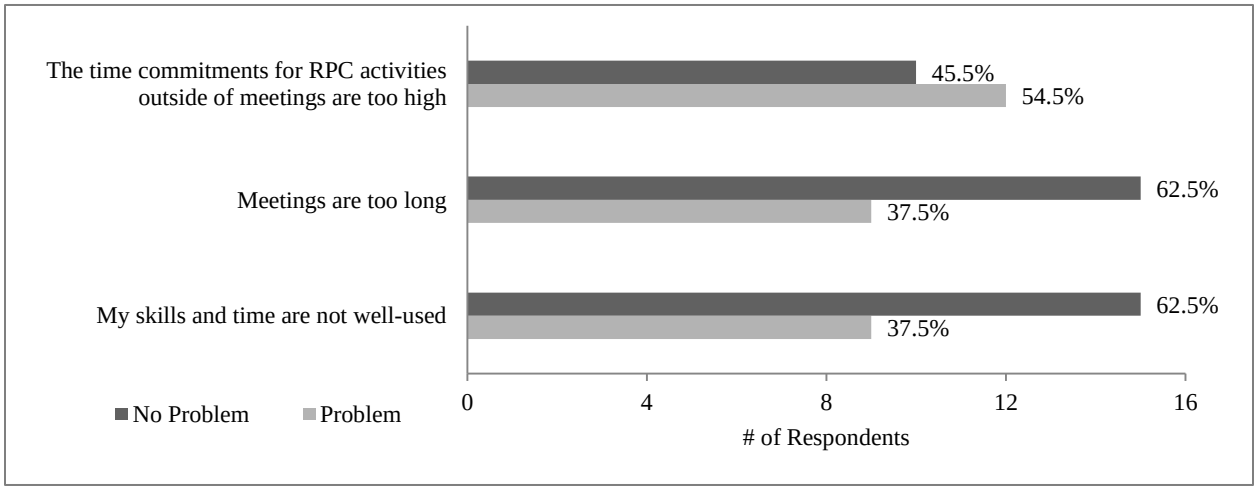
> *"I'll say there were maybe three to five additional dates during the month from the RPC that I did not anticipate. And that was, for my schedule which is so full, it was too much for me."*

During meetings, the consensus decision making process itself takes time. The RPC Innovation Project includes many stakeholder perspectives, and RPC members discuss different viewpoints prior to making decisions. When consensus is not reached immediately, RPC members may return to the same topics over multiple meetings. Examples include attendance policy determination, funding allocations, and inclusion of missing voices. Some RPC members expressed frustration in meeting evaluations with the slow pace of the consensus process. Conversely, others felt RPC members as a whole needed more time in meetings when deliberating several issues because they had run out of time to make multiple decisions by the end of very full meetings:

> *"…having to work within the parameters and deadlines is a challenge. But in a way, it pushes people to have to make decisions and to move forward…coalitions are groups you can go around in circles for a long time before a decision is made or action is taken."*

The RPC survey in December 2013 similarly shows that the time commitment to be part of the RPC Innovation Project could be problematic for some (exhibit 11).

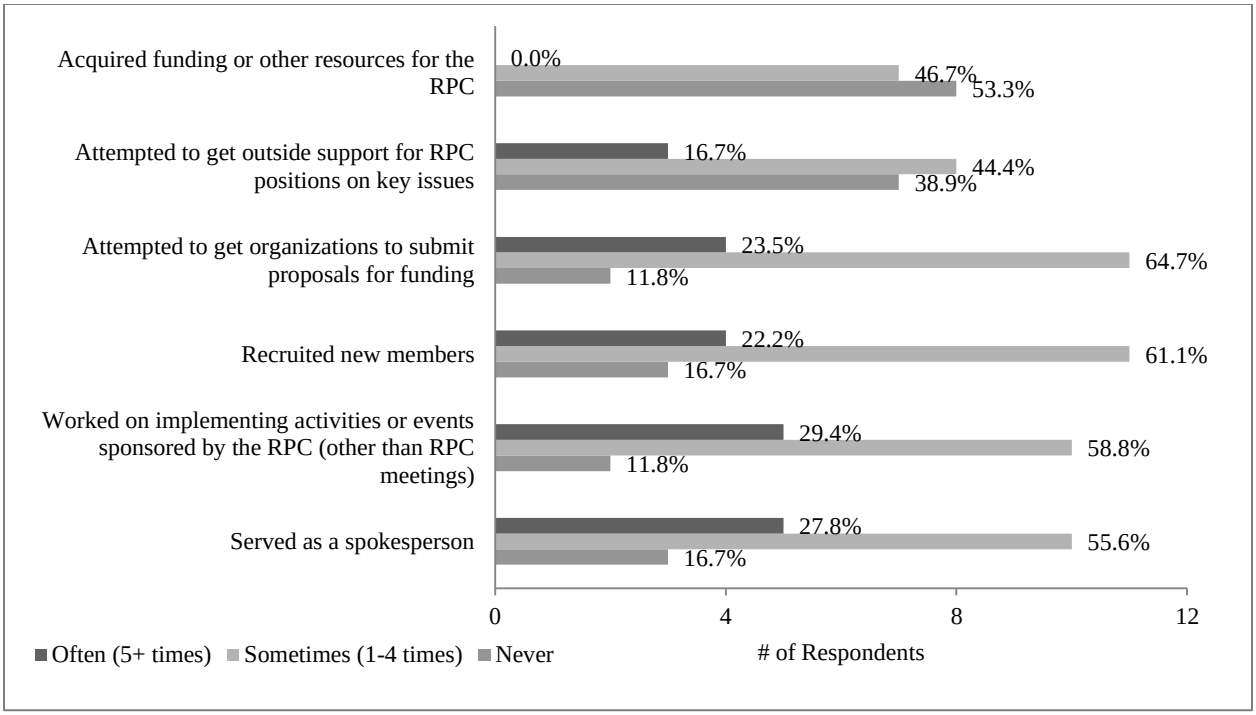
Exhibit 11. Problems for Participating in the RPC Innovation Project, by Number of Respondents, December 2013*



*Does not add to the total number who completed the survey (*n*=31) because we omit those who skipped items or marked "not applicable".

The concerns about time, particularly time for activities outside of committee and full RPC meetings may explain the limited involvement in non-meeting activities among RPC survey respondents (exhibit 12).

Exhibit 12. Things I've Personally Done for the RPC Innovation Project Over the Last Year, December 2013*

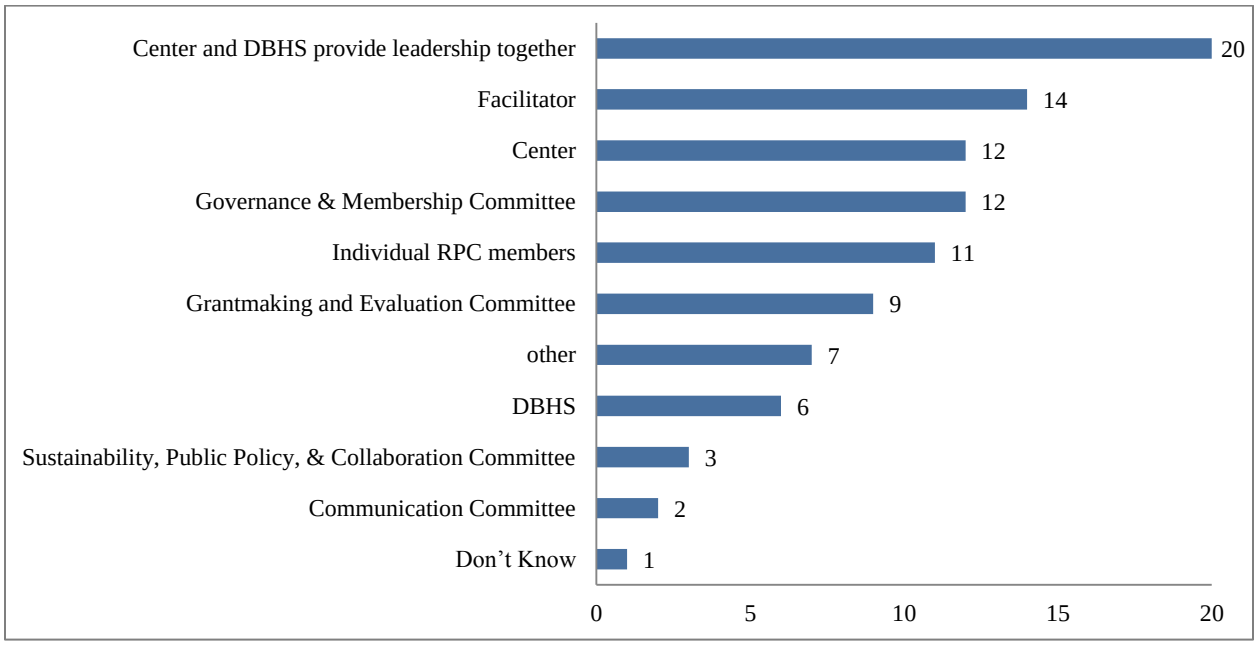


*Does not add to the total number who completed the survey (n=31) because we omit those who skipped items or marked "not applicable". Percentages may not add to 100% because of rounding.

5.4 Balance of Power and Leadership

Power and leadership is a key dimension for studying the RPC Innovation Project's community driven processes. In the early stages of the RPC Innovation Project, the Center and DBHS worked off the Innovation Workgroup's blueprint and often set precedents or presented a limited set of options to RPC members about structure and process. In doing so, they allowed the first RPC members to move as quickly as possible into making decisions about grants. Examples include membership and consensus decision making. As a result, RPC survey respondents recognized leadership as coming from the Center and DBHS together (exhibit 13).

Exhibit 13. Who Provides Leadership for the RPC Innovation Project? (Select all that apply.)



In early phases, this seemed acceptable. One interviewee noted:

> *"You can't expect community members to come in and take over immediately. A collaborative, any collaborative, it has to start somewhere and it has to start with strong leadership. Otherwise, it falls apart right away …"*

Some interviewees expected and observed that RPC Innovation Project leadership and activities would change over time. According to one interviewee, it took about a full year for committees to work effectively and for meetings to run smoothly. The RPC members were:

> "*…coming towards a better conception of what the potential of the RPC actually was and is… it took time to kind of figure it out."*

Yet, some felt that the RPC members were not taking enough of a leadership role as the RPC Innovation Project moved forward. First, Standing Committees often adopted processes established by the Center, DBHS, and the facilitator rather than considering and deciding on processes on their own. Second, RPC members and committees had limited influence over budgets and meeting agendas. One interviewee noted:

> *"… if I would give any feedback… it would be to really specifically ask the members what they would like to see out of the next meeting or topics that they want to discuss."*

Consequently, respondents of the RPC survey commonly reported that RPC members had less influence than other partners (exhibits 14 and 15).

Exhibit 14. Influence in Deciding Actions and Policies for RPC Innovation Project, by Partner, December 2013*

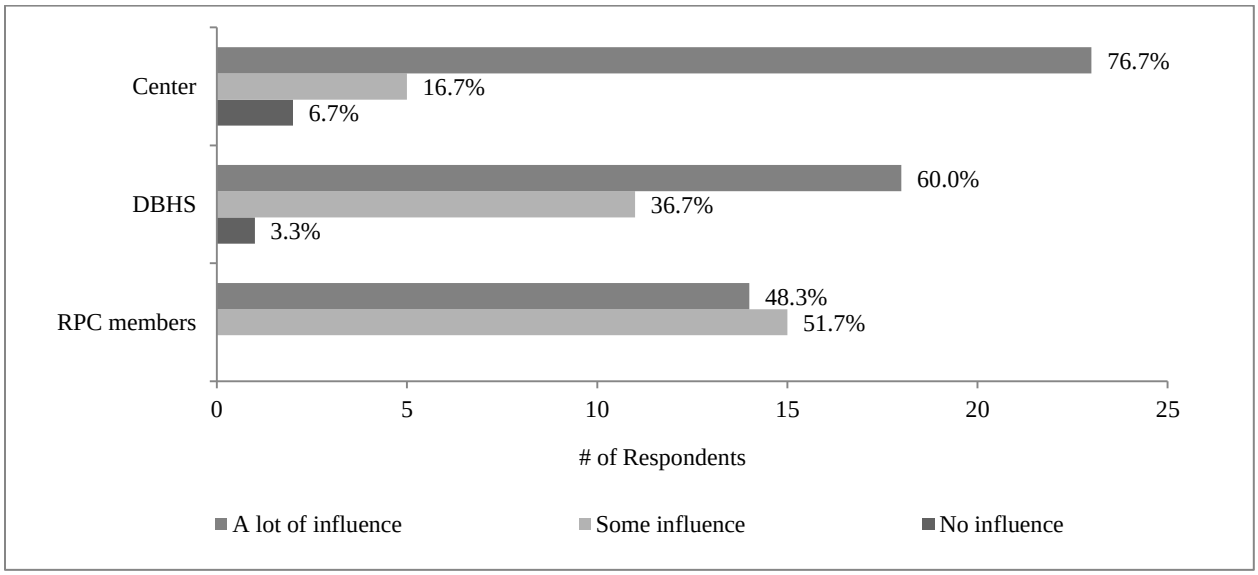
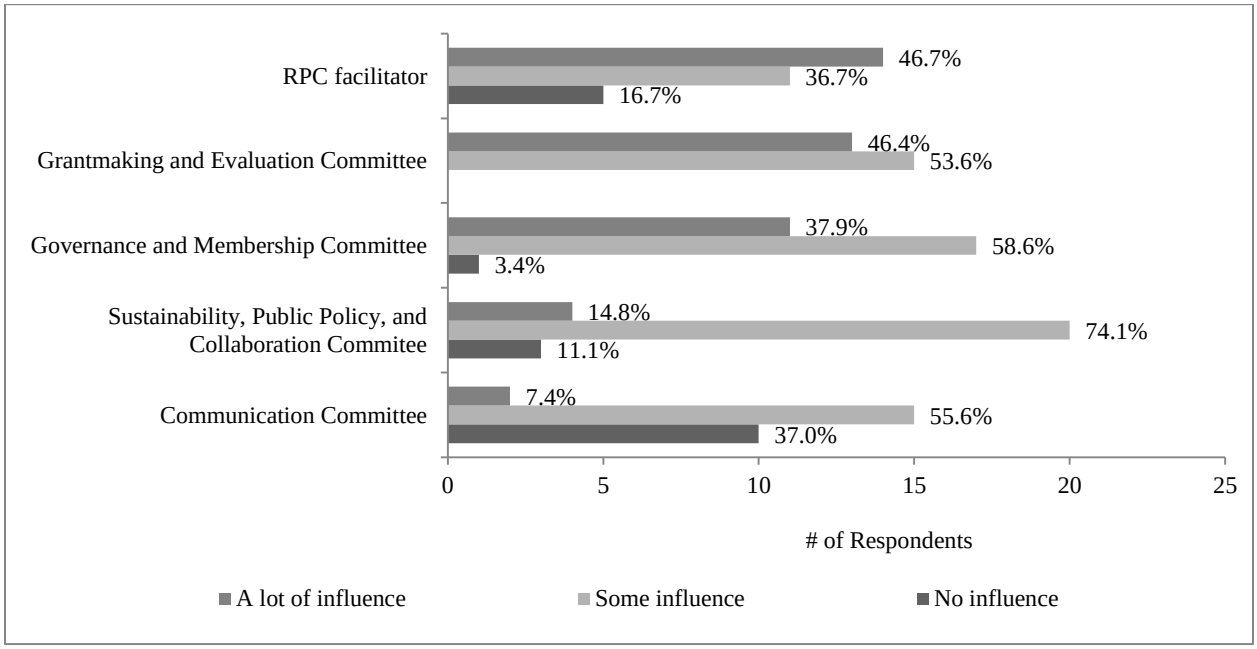


Exhibit 15. Influence in Deciding Actions and Policies for RPC Innovation Project, by Facilitator and Committees, December 2013*



*Does not add to the total number who completed the survey (n=31) because we omit those who skipped items or marked "not applicable"

5.5 Discussion

In considering community participation, we examined how the dimensions of diversity, time, and leadership intersect to affect the Innovation Project's implementation. First, through intentional recruitment, the RPC Innovation Project has achieved considerable diversity and includes a mix

of lay and professional RPC members. An important strategy for accommodating all RPC members has been to take time to complete processes thoroughly and in a manner that allows both lay and professionals to engage regardless of background or experience. As a result, RPC members devote hours to taking part in the RPC Innovation Project's processes and deliberations, indicating a high degree of engagement. However, many report time commitment as a problem, and limited time may explain RPC members' minimal role on non-meeting related activities, including getting organizations to develop and submit proposals for funding.

Second, the RPC Innovation Project has not successfully engaged a number of key stakeholder groups, including hospitals and law enforcement, even after trying to recruit these specific groups. This is a notable gap given desires to prevent hospitalization and encounters with the justice system among persons at risk for crisis. However, this gap may also reflect how RPC members prioritize members' time commitment to the project over these stakeholder perspectives. RPC members decided not to permit co-membership (e.g., one hospital perspective represented by two participants who split time and responsibilities), perhaps at the expense of including some important professional organizations.

Third, exhibit 12 shows that many survey respondents view the Center and DBHS together as leading the RPC Innovation Project, and exhibit 13 shows that survey respondents view RPC members as having less influence than the other entities in deciding actions and policies. One explanation is that RPC members have access to leadership roles, but explicitly or implicitly decline because they already volunteer considerable time to the RPC Innovation Project. Another explanation is that the Center and DBHS maintain leadership so that RPC members can devote their time to deliberating different membership, governance, and grant options presented to them.

Although the diversity, time, and leadership dimensions help to demonstrate community participation within the RPC Innovation Project, it remains unclear the extent to which the RPC Innovation Project demonstrates a community driven process. Entities have yet to agree on how they collectively define community-driven and what they expect of each entity in order to achieve a community-driven process. The following quotes demonstrate uncertainty:

> *"Does [community-driven] mean no staff and no support? Does it mean that people do everything themselves? Or is it some other version"*
>
> *"If it isn't community driven then what is it… let's call it what it is…let's be sure that everybody is aware of what it is and right now I don't feel that it's driven per se. I think it's informed."*
>
> *"There are times where it is community driven and times that it is community informed…with the community driven, I would say that's when RPC has the opportunity to go all the way with the decision making and… maybe need less staff support. And then I would say there are times where it's community informed when the … staff and planning committee … are presenting something for the RPC to really review, analyze and … provide their opinion…"*

6.0 Respite Services Provided by RPC Grantees

As described in the sections above, the RPC partners developed a granting process to disperse three rounds of grant funding between 2013 and 2015. To date funds have been dispersed in two rounds to a total of seven community-based organizations (exhibit 16).

Exhibit 16. Organizations Funded as a Result of the Granting Process

Round 1 Grantees	Round 2 Grantees
▪ Capitol Adoptive Families Alliance ▪ Del Oro Caregiver Resource Center ▪ Iu-Mien Community Services ▪ Turning Point Community Programs, in partnership with Welcome Home Housing	▪ Children's Receiving Home ▪ Saint John's Shelter Program for Real Change ▪ Transitional Living Community Support

As described in the beginning of this report, AIR reviewed documents and conducted interviews with staff and clients from the Round 1 grantee organizations. We interviewed a total of 17 staff and clients from the following Round 1 grantees: Capital Adoptive Families Alliance, Iu-Mien Community Services and Turning Point Community Programs/Welcome Home Housing. We conducted 10 client interviews and 7 staff interviews. AIR plans to interview the fourth Round 1 grantee, Del Oro Caregiver Resource Center, during the final phase of interviews in 2015. This section:

- Defines respite, based on the data collection activities conducted with the four Round 1 grantees, and discusses how community-based organizations put respite into practice
- Describes outcomes, as discussed and reported by grantee staff and clients

6.1 Dimensions of Respite and How Grantees Put Respite Into Practice

While each grantee has a different approach to respite based on the population they serve, several cross-cutting dimensions of respite emerged during interviews with Round 1 grantee staff and clients. These dimensions are not separate and distinct from one another, but rather feed into each other to create what we interpreted as an overall "respite state of mind" (exhibit 17). For example, some interviewees described how providing time away from daily lives in a safe and supportive environment can help individuals with lived mental health experience gain clarity and skills to move forward in their lives.

Exhibit 17. Dimensions of Respite Described by Grantee Staff and Clients

In the sections that follow, we describe each dimension of respite, how grantees put the dimension into practice and provide perspectives from clients and staff on each dimension.

6.1.1 Mental and Physical Break

A period of time that provides physical distance or decreased exposure to emotional stressor.

All grantees provided clients with time and physical space away from their current situations; the manner in which this time and space was offered varied. Some grantees provided time and space for caregivers to be away from their loved ones by providing in-home and out of home care. Capital Adoptive Families Alliance offered events where parents could drop off their children at supervised activities and return a few hours later. Del Oro Caregiver Resource Center contracted with outside vendors to provide clients with a choice among respite options such as hourly in-home respite, 24 hour in-home respite, adult daycare respite and institutional respite. Other grantees provided time and physical space for persons at risk for crisis. Turning Point Community Programs offers individuals the opportunity to take a break in a temporary out of home space for a couple of weeks. Iu-Mien Community Services also provides out of home space for Iu-Mien community members to gather for a few hours each week. Exhibit 18 illustrates terms used by grantee staff and client interviewees to describe taking a "mental and physical break":

Exhibit 18. Perspectives on Taking a Mental and Physical Break

▪ "Rejuvenating" ▪ "A sense of peace" ▪ "Get my thoughts together and figure out what I needed to do" ▪ "Lighter" ▪ "Calm" ▪ "Breathing space" ▪ "Don't have to worry" ▪ "Step away, get away"	▪ "Rest, rest my heart" ▪ "Relief" ▪ "Distraction" ▪ "Time off" ▪ "Stop thinking, take your mind away" ▪ "Relax" ▪ "Healing time" ▪ "Clarity"

6.1.2 Safe Place

"An environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together."[9]

Safe place addresses physical and emotional safe spaces. Grantees offered their clients a physically secure environment free of physical threats. For example, Turning Point Community Programs' Abiding Hope Respite House is situated in a safe neighborhood. Grantees also offered clients emotionally secure environments. Abiding Hope Respite House provided a home like atmosphere instead of an institutional one, and providing home-cooked meals to residents reinforced feelings of comfort. In contrast, Iu-Mien Community Services' program provided emotional security by offering an affirming environment where participants could speak their native language and hold traditional celebrations. A client at Iu-Mien Community Services stated:

> *"We have a Mien saying that goes, the sky is too far to reach and the earth is too low. It means that when you are desperate, you have nowhere to turn and it just seems like everything is impossible, but when I attended the group, the people there, they tell me with words, they tell me, they sustain me with their words and they tell me, do not worry, do not be frightened."*

6.1.3 Not Alone

The realization that others face similar challenges to you and do not judge those challenges, your reactions to them, or means of coping.

Grantees provided an atmosphere where clients could build relationships with other community members, including peers and individuals from different generations. Capital Adoptive Families Alliance provided planned activities for children, which allowed time for parents to speak with other parents about their experiences and connect with children from other families. A parent at Capital Adoptive Families Alliance stated:

> *"Because the group itself, together creates an atmosphere that does give relief, it does give some down time, because you know that you're around a group people that are in the same boat that you're in, that aren't, you're not, I don't worry if my, my child who has anxiety attacks, has an anxiety attack around these people, because they're not going to freak out,"*

Iu-Mien Community Services provided a time and place where community members gathered, shared experiences, and subsequently realized others faced the same challenges.

[9] Williams, R. (1999). Cultural safety – what does it mean for our work practice? Australian and New Zealand Journal of Public Health, 23(2), 213-214.

6.1.4 Looking Forward

Leaving in a more positive emotional state than prior to the respite program.

One way grantees helped their clients in looking forward was having services delivered by peers and professionals. These individuals provided clients with skills and tools to help them work through emotional triggers and difficult situations that may have put them at risk for mental health crises prior to receiving respite (exhibit 19).

Exhibit 19. Services Delivered by Peers and Professionals, by Grantee

Grantee	Kinds of Services Delivered by Peers and Professionals
Capital Adoptive Families Alliance	Recreational therapy to adoptive children with complex mental needs
Del Oro Caregiver Resource Center	Development of individualized respite plans
Iu-Mien Community Services	Introduction of mental health concepts and how to cope with mental health challenges
Turning Point Community Programs	Evidence-based practices such as solution-focused brief therapy and dialectical behavioral therapy

Grantees also linked clients to other community organizations for additional support that may be needed beyond respite. Examples of organizations that grantees referred their clients to included: mental health agencies and service providers; adoption agencies, board and care facilities, medical clinics, and domestic violence organizations.

The terms and language used by grantee staff and clients to describe "looking forward" illustrates the restorative nature of the respite services. (exhibit 20)

Exhibit 20. Perspectives on "Looking Forward"

▪ "Ready to go again" ▪ "Recharge" ▪ "Energized" ▪ "Empowered to discuss symptoms" ▪ "Get stronger"	▪ "Provide tools" ▪ "Move forward" ▪ "Recuperate" ▪ "Regenerate" ▪ "Heal"

6.2 Outcomes, as Discussed and Reported by Grantee Staff and Clients

The next section presents perspectives from Round 1 grantees on the outcomes of their respite programs. It is important to note that these are observations from clients and staff on both the outcomes they want to monitor and outcomes they have achieved so far. These self-reported perspectives come from a small number of interviews and progress reports and are not intended to be conclusive about respite effectiveness.

Based on the RPC Innovation Project's logic model (Appendix F) and grantee interviews, we grouped outcomes into three categories: 1) Intermediate outcomes that address utilization of respite services; 2) Intermediate outcomes that address client experience and client satisfaction with respite services; 3) Long-term outcomes that address emergency department (ED) visits, psychiatric hospitalizations and institutionalization.

6.2.1 Intermediate Outcomes: Utilization

All grantees provide utilization data to the RPC partners, including the number of people served, and some grantees exceeded their goals (exhibit 21).

Exhibit 21. Anticipated Versus Actual Number of Clients Served by Round 1 Grantees

Grantee	Anticipated Number of Clients	Actual Number of Clients
Capital Adoptive Families Alliance	35 unduplicated families	Served 44 unduplicated families (as of 9/30/13)
Del Oro Caregiver Resource Center	11 unduplicated clients	21 unduplicated clients (as of 9/30/13)
Iu-Mien Community Services	97 unduplicated clients	140 unduplicated clients (as of 3/30/2013)
Turning Point Community Programs	48 unduplicated clients	28 unduplicated clients (as of 6/30/13)

Note: figures in table are derived from grantee scope of work, progress reports, yearend reports, and organization's annual reports.

6.2.2 Intermediate Outcomes: Experience

Through our interviews with 7 staff and 10 clients from three grantee organizations, we learned about many positive experiences of receiving respite services, such as helping clients to feel not alone, safe, able to look forward, etc. (see above in Section 6.1. Dimensions of respite). Further, two residents at Abiding Hope House described how their participation in the respite program provided them with the opportunity to learn and practice new coping skills to help them better handle situations after they are back in the community. A resident at Abiding Hope House stated:

> *"I came here and just started digging in, learning some new coping skills with the help of staff, I was always writing or I brought my computer with me so I was always looking up new ways of dealing with things so when I go back out I can be successful… you know practicing it here… I would practice my assertive skills and the reinforcement skills that I have…I'm very proud of myself of all the progress that I've made."*

Additionally, Del Oro and Turning Point Community Programs administered surveys and analyzed the results in an effort to assess clients' perceptions about the respite services received (Appendix G and H). Thirteen Del Oro clients out of 16 (81%) responded excellent or good to the statement "The respite care was beneficial to my well-being" between January 2013 and

September 2013. Similarly, Abiding Hope House Residents from March 2013 to January 2014 reported a satisfaction rate of 82%.

6.2.3 Long-Term Outcomes: Emergency Department (ED) Visits, Psychiatric Hospitalizations and Institutionalization

Most grantees do not have formal data collection processes in place to measure outcomes related to emergency department (ED) visits, psychiatric hospitalizations, and institutionalization. However, some grantees expressed interest in, or are in the process of, determining how they might measure such outcomes.

Capital Adoptive Families Alliance and Turning Point Community Programs staff and clients offered their viewpoints on respite's effect on long term outcomes. One parent from Capital Adoptive Families Alliance shared her opinion about appropriate expectations for respite services. In response to a question about whether the parent network has made a difference in needing urgent care, she responded: "*I'm not sure that I could say that it has. I think that would be a huge expectation and responsibility for this group to be that place… when we're at those moments, I need the psychologist and the psychiatrist, and that's fine."* From this parent's perspective, accessing these services or the next level of care may be appropriate, even with the availability of respite services.

In contrast, a staff member from Turning Point Community Programs felt that the coping skills that residents acquired during their stay at Abiding Hope House (see Section 2 "Intermediate outcomes: experience" above) provided residents with another way to manage issues that arise besides going to the hospital. A staff member at Turning Point Community Programs stated:

> *"…it's aiding them in feeling like they don't really need hospitalization. If they now know, if I'm having this kind of trigger…instead of just feeling like the only way out is just, you know, go to the hospital…it's helping them to be more dependent on themselves and on the skills that they have acquired."*

In addition to hearing from staff, Turning Point Community Programs conducts a follow-up phone survey with residents. According to Turning Point Community Programs' annual report from March 2013 to January 2014, they were able to reach 16 people 3 months after leaving Abiding Hope. Of these 16, four self-reported having a hospitalization. While these data are a helpful starting point, they do not help us to answer whether respite changed hospitalization risk. We do not know what would have happened in the absence of respite. The same four people could have been hospitalized in the absence of respite, suggesting that respite maintained the status quo. Or, more than four people could have been hospitalized in the absence of respite, suggesting that respite prevented hospitalizations for some individuals.[10]

[10] Determining the effect of respite on hospitalization is outside of the scope of our evaluation objectives.

6.3 Sustainability Strategies Under Consideration

Sustainability strategies described during the interviews in March 2014 included: additional grant funding, hosting fundraising events, and charging for services. Most staff discussed actively looking into funding opportunities through other community organizations. All of the grantees fundraise in some capacity. For example, each organization features a link to a donation page on their website for individuals to contribute funds. Some grantees host fundraising events, such as an annual banquet. Another grantee recently established a fundraising committee, comprised of volunteers, to organize events. One grantee is considering charging individuals to attend its most popular respite event. Other tactics discussed were trimming costs (for example, cutting one respite activity), collaborating with similar organizations and using discretionary funds. A unique sustainability concept proposed by Capital Adoptive Families Alliance is "peer-to-peer" respite in which parents form relationships with one another at the organization's structured respite events to eventually provide respite to one another outside of funded activities.

6.3.1 Discussion and Next Steps

The RPC Innovation Project funded four organizations in Round 1 to provide respite services to different populations. Even though the people these organizations serve vary, we found cross-cutting dimensions of respite that were consistent across organizations. All the respite services helped clients to take a mental or physical break, gave clients a safe physical and emotional space to spend time, supported clients in feeling not alone, and prepared clients to look forward beyond the time in respite.

Grantees had varying capability to study outcomes of their services. All grantees reported the most immediate outcomes showing utilization of respite services, and AIR interviews with clients and staff provided many instances of client experiences. It was more of a challenge for grantees to evaluate themselves on long term outcomes on emergency department (ED) visits, psychiatric hospitalizations and institutionalization. Given the size of these programs and the differences in their foci (i.e., planned respite vs residential), some long term outcomes may not be feasible for grantees to capture.

7.0 Next Steps

This first report for the RPC Innovation Project evaluation reflects data collected from document interviews, surveys, and interviews through June 2014 only. Subsequent evaluation reports will include additional document reviews, interviews, and surveys. (exhibit 22)

To explore the partnership between DBHS and the Center in greater detail, AIR conducted group interviews with DBHS, the Center, and RPC Co-Chairs in July 2014. Topics addressed in the interviews include: how the RPC Innovation Project fits within organizational mission, culture and structure; expectations of each partner's role and responsibilities; relationship between partners; and lessons learned and best practices. The findings from these interviews will be reported in future evaluation reports.

In addition, AIR will administer the RPC and community surveys again in 2014 and 2015 and conduct additional interviews with partners in 2015. AIR will also continue studying the dimensions of respite as well as how grantees and clients report both intermediate and long term outcomes with Round 2 and Round 3 grantees.

Exhibit 22. Evaluation Timeline

	2013		2014				2015				2016
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
RPC Document review											
RPC interviews											
RPC survey											
Community survey											
Grantee Document Review											
Grantee site visits											

8.0 Appendices

Appendix A. Innovation Plan

MENTAL HEALTH SERVICES ACT

Innovation Component of the Three-Year Program and Expenditure Plan

June 21, 2011

EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: SACRAMENTO

County Mental Health Director	**Project Lead**
Name: Mary Ann Bennett Telephone Number: 916-875-9904 E-mail: Bennettma@saccounty.net	Name: Michelle Callejas, MFT Telephone Number: 916-875-6486 E-mail: Callejasm@saccounty.net
Mailing Address: Sacramento County Division of Behavioral Health Services 7001-A East Parkway, Suite 400 Sacramento, CA 95823	Mailing Address: Sacramento County Division of Behavioral Health Services 7001-A East Parkway, Suite 300 Sacramento, CA 95823

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

Mary Ann Bennett	6-21-11	Deputy Director, DBHS
Signature (Local Mental Health Director/Designee)	Date	Title

Executive Summary

Introduction

Since the passage of Proposition 63 in November of 2004, Sacramento County has worked diligently on the planning and implementation of the Mental Health Services Act (MHSA). To date, we have planned and implemented the following components: Community Services and Supports (CSS), Workforce Education and Training (WET), Prevention and Early Intervention (PEI) and Technological Needs. Many programs across all components are fully implemented and yielding positive outcomes, while others are in various stages of implementation.

Sacramento County started the Community Planning Process (CPP) for Innovation in September of 2010, with an official community Kick-Off Meeting in November of 2010. An Innovation Workgroup, comprised of community members representing various stakeholders, was established to develop a draft plan for Sacramento County's Innovation Plan. In developing the plan strategies and soliciting community input, the Division of Behavioral Health Services (DBHS) coordinated a total of three (3) full-day Workgroup meetings, one (1) half-day Workgroup meeting, two (2) large Community Meetings, and ten (10) small Community Meetings with unserved and underserved racial, cultural and ethnic communities. DBHS is extremely grateful for all the work completed by the Workgroup Members and the community. In total, over 1400 volunteer hours were put in to developing Sacramento's Innovation Plan.

The proposed Innovation Plan is referred to as the **Respite Partnership Collaborative**. Sacramento County will contract and partner with a community-based organization which will serve as the Administrative Entity for this project. Sacramento seeks to learn whether this partnership can expedite the release of program funding into the community, lead to the leveraging of new and existing resources, and lead to new partnerships that can help address crisis and other mental health issues in our community. Additionally, the County wants to learn whether the formation of a Respite Partnership Collaborative that is community-driven, rather than county-driven, can lead to effective crisis respite programs that serve all age groups in various locations within our community.

Innovation Funding Request and Time Line

Sacramento County is requesting $8,810,600 in Innovation funding to implement this project. The project has four (4) phases and will begin in July of 2011 and end in June of 2016.

EXHIBIT B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: Sacramento
Work Plan Name: Respite Partnership Collaborative

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

The Sacramento County Community Planning Process for Innovation officially began in September of 2010 with MHSA Steering Committee support. On November 30, 2010, a community Kick-Off meeting was held and 75 community members attended. At this meeting, prior MHSA planning processes were reviewed and the Innovation component was explained to the community. A schedule for future planning meetings was presented and an invitation to stay involved was extended to those in attendance.

Following the Innovation Kick-Off, an Orientation meeting was held January 12, 2011, for the Innovation Workgroup, a committee of twenty individuals representing diverse stakeholders that agreed to work on the Innovation Plan. A major focus of this meeting was how the group would use Levels of Agreement to achieve consensus for decision-making throughout the planning process. (See Attachment D)

In total, three (3) full-day and one (1) half-day Innovation Workgroup meetings were held from January through April. Each meeting was publicized by the MHSA internet distribution list that goes to approximately 1700 recipients, as well as at various Division and community meetings, and the public was invited and encouraged to attend. In addition, time for public comment was built into each Innovation Workgroup meeting agenda.

At the first full-day Innovation Workgroup meeting, members reviewed data from prior MHSA planning processes, crisis statistics, system partner data related to crisis, results from the Innovation Survey, and data from the local Hospital Council meetings. One of the Workgroup members provided information on various peer-run services models and the DBHS Deputy Director presented the DBHS vision for crisis services. (See Attachment E)

At the second Workgroup meeting, members developed a definition of crisis and developed five (5) preliminary strategies to be presented to the community for feedback. (See Attachments F and G) The strategies were presented at two (2) large community

and ten (10) smaller meetings with unserved and underserved racial, cultural and ethnic communities. At each of the community meetings, participants were asked what could strengthen or improve each strategy. In addition to providing input into specific strategies, overall input was solicited, especially from the smaller culturally specific meetings. In an attempt to reach more community members, the larger meetings were held on a Saturday morning and a Tuesday evening at two different locations. (See Attachment H)

The final two Workgroup meetings focused on refining the strategies based on community feedback, identifying priorities, and preparing final recommendations to move forward to the MHSA Steering Committee. (See Attachments I and J)

On May 5, 2011, the MHSA Steering Committee reviewed and discussed the Draft Innovation Plan and unanimously supported moving forward with finalizing the Plan for submission to the Department of Mental Health and the Mental Health Services Oversight and Accountability Commission.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

A twenty member Innovation Workgroup representing a wide array of stakeholders was established to explore innovative approaches to address the issue of crisis in Sacramento County. Six members were consumer advocates, five members were family advocates (representing adults and children), two members were DBHS representatives, two members were mental health providers and one member each represented the Mental Health Board, law enforcement, Disability Rights of California, Cultural Competence and physical health. (See Attachment B)

As mentioned above, nine small groups were convened by community members with assistance from DBHS staff to solicit input on the strategies developed by the Innovation Workgroup. The following communities participated in the small meetings: Latino, Hmong, Vietnamese, Chinese (Cantonese speaking), Mien, LGBTQ, Muslim, Native American, African American and Transition Age Youth.

Overall, the estimated number of volunteer hours put in by community members was 1,443. (See Attachment C for more detail)

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The Draft Innovation Plan was posted from May 17, 2011, through June 16, 2011. A Public Hearing was conducted by the Mental Health Board on Thursday, June 16, 2011, beginning at 6:00 p.m., and was held at the Department of Health and Human Services Administrative Building at 7001-A East Parkway, Conference Room 1, Sacramento, California 95823.

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There were several comments received during the 30-day public review and comment period. Below is a summary of the comments and the Division of Behavioral Health Services' response.

Comments

- The Division should require or strongly suggest to the administrative entity that the MHSA Steering Committee be consulted in the selection of the evaluator.
- Evaluation is important and we should emphasize learning in real time rather than waiting for evaluation feedback. If we develop learning collaboratives, we can test processes out through the PDSA (Plan, Do, Study, Act) model and make real-time changes. We have very little time and should not waste any of it waiting for an evaluation.
- There appears to be no definition of respite care in the document.
- Concerns about the legality of the Division contracting with an administrative entity.

Members of the DBHS Cultural Competence Committee organized and facilitated various focus groups within their respective communities during the Innovation Community Planning Process. In a written statement, members of the committee expressed appreciation for the manner in which comments from the community focus groups were incorporated into the Innovation Workgroup's draft plan. Additionally, the Cultural Competence Committee reviewed the Innovation draft plan and documented what they liked about the plan:

- Important to have respite available
- Adults in crisis with dependent children – this group of people often falls between the crack so it is good that they are included as one of the populations to be served
- Importance of designing respite option that is culturally responsive (population #2 in Attachment A)
  - Addresses program design that is culturally appropriate and incorporates staff that is culturally and linguistically competent.
  - Involves working with traditional community leadership to design the program

- Meaningful involvement of community leaders/cultural brokers/representatives in the Respite Partnership Collaborative
- Culturally responsive traditional healing practices
- Community based programs providing services based on community practices.

DBHS Response

This Division will work with the Administrative Entity and advocate that one or more members of the Steering Committee be included in the competitive bid process used to select the evaluator.

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The Division is aware that there is no formal definition included in the Innovation Plan for "Crisis Respite." This issue arose during the Innovation Workgroup meetings and there were many rich discussions about the topic. What came to light was that "respite" has many meanings to different individuals and groups in our community. In order to ensure flexibility in program design and allow for innovative approaches, the Workgroup elected not to include a formal definition.

With regard to concerns about contracting with an Administrative Entity, DBHS will work with County Counsel on any legal matters pertaining to this project.

The Division extends its appreciation to the Cultural Competence Committee for playing such a vital role in arranging for the small community meetings focused on specific cultural and ethnic groups. The participating agencies mobilized in a very short timeframe, conducted the meetings, and provided written responses to the Division. The feedback was very helpful in finalizing the Plan. The Division also appreciates the comments that were submitted in support of the Innovation Plan and will consider all feedback as we move forward with implementation.

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EXHIBIT C
(Page 1 of 9)

Innovation Work Plan Narrative

Date: June 21, 2011

County: Sacramento

Work Plan #: 1

Work Plan Name: Respite Partnership Collaborative

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☒ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Promote interagency collaboration: There were a couple of reasons for selecting the promotion of interagency and community collaboration regarding the issue of crisis. Throughout all of the MHSA Community planning processes, crisis services and help in a crisis across all age groups has been a recurring community concern. Over the past several years, Sacramento County, like many other counties across the state, has faced reductions in funding for mental health services. One of the consequences of reduced funding was the closure of the Sacramento County Crisis Stabilization Unit which subsequently resulted in an increase in local emergency room visits and hospitalizations. This situation led Sacramento County's MHSA Steering Committee to support an Innovation Project focused on crisis and alternatives to hospitalization.

During the numerous community planning processes, community members and providers have given positive feedback about how extensive and inclusive the planning has been. However, they have asked for greater input into the design and implementation of the mental health services created from the planning processes. This Innovation project provides opportunities for community partners to come together to design and implement a range of respite services that can respond to crisis situations across all age groups.

The essential purpose of the Sacramento County Innovation Project is to test whether a community-driven process, that includes decision-making and program design, will promote stronger interagency and community collaboration. Additionally, the County seeks to learn whether this community-driven collaborative approach can lead to new partnerships that can maximize existing resources to establish a continuum of respite services that will reduce mental health crisis.

Increase the quality of services, including better outcomes: The secondary purpose of this Innovation Project is to determine whether this community-driven collaborative leads to an increase in the quality of services being delivered, including achieving better outcomes. Given that there is a dearth of respite options in the county, it is expected

that building a continuum of services to meet different crisis needs will improve the quality of services for those experiencing a crisis and ultimately improve their outcomes.

In implementing a range of respite options designed by community partners, DBHS will test whether a process unlike the traditional government process now in place will facilitate a different outcome, be more expedient, improve relationships in the community, and create greater trust between the community and the County. It will also test whether adopting a model that gives community members program choice will improve the quality of services and produce better outcomes.

EXHIBIT C
(Page 3 of 9)

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

After an extensive review and discussion of crisis data and statistics in Sacramento County, the Innovation Workgroup grappled with what makes the issue of crisis so difficult to solve and how can it be approached in an innovative way. Through a series of Innovation Workgroup meetings and twelve (12) small and large community meetings, an Innovation Project was developed that proposes to establish a Respite Partnership Collaborative (RPC). The RPC will come together to forge new partnerships and establish a continuum of crisis respite services.

What makes this Project innovative and what will create the learning opportunities is in how the project will be developed and administered. In the past, DBHS has heard from mental health providers that although we may have done a good job in planning, we have sometimes not integrated community feedback as well into implementation. Both the community and providers have expressed a desire to have more of a voice in program development and implementation. Additionally, there has been frustration with the amount of time it takes to get funding out into the community. The rules and restrictions inherent in government bureaucracy create barriers, delays and limit creative opportunities.

In responding to this feedback, the County will select an Administrative Entity to receive and administer the funding for this project. The chosen Administrative Entity will be experienced in working with collaborative efforts and serve to bring community members and system partners together to work in a transparent and inclusive way. The Administrative Entity will not be a provider of services, but they will serve as a member of the RPC. They will facilitate the formation of the Respite Partnership Collaborative, administer an award selection process, oversee the distribution of funds and manage contracts or awards. They will host and facilitate meetings and develop and implement a communication plan and an evaluation framework.

This Innovation Project proposes to allow the community, through the formation of a self-governing collaborative, to address program implementation in a new and innovative way. Membership in the RPC will be comprised of community members that have a commitment to the mission of the project, including but not limited to consumers, family members of consumers, representatives of the five populations to be served, mental health agencies, non-traditional mental health providers, homeless programs, faith-based providers, system partners, cultural brokers/representatives, advocates and other subject matter experts. MHSA principles and general standards identified in the MHSA CCR, Title 9 Section 3320 will be adhered to and will guide the development of a

governance structure and decision-making process that will be supported by both the County and the Administrative Entity.

A process will be developed asking the community to propose program models that can provide respite options for up to five different target populations. The five populations are: Parents with Seriously Emotionally Disturbed children that need a break; Teens and TAY in crisis; adults, including older adults in crisis; adults in crisis with dependant children; and respite options to address specialized cultural or ethnic population(s).

The RPC will work with the Administrative Entity on establishing a selection process. Once awards are made, the administrative organization will develop contracts and distribute funds. The RPC will assist in overall coordination and implementation of respite programs including, but not limited to: leveraging new and existing community resources; tracking and coordinating respite options; providing linkage with other MHSA programs including WET to deliver Trauma Informed Care training; host regular stakeholder meetings to keep the community updated on progress; and participate in a Project evaluation. (See Attachment A)

EXHIBIT C
(Page 5 of 9)

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

This Innovation Project is expected to contribute to learning in several ways. At a macro level, it is anticipated that both the County and the community will learn whether a community-driven collaborative planning approach can lead to new partnerships, maximize existing resources, and result in a better coordination of care. The County hopes to learn whether turning over decision-making authority and program development to the community will promote and enhance successful interagency and community collaboration. The outcomes of this learning will potentially inform future decision-making and program development in the area of mental health. Additionally, other government agencies faced with similar bureaucratic barriers may be able to consider a similar type of approach.

On a micro level, based on community response, DBHS will learn what kind of respite services the community values. The hypothesis is that a community-driven collaborative approach will lead to new partnerships that can establish innovative mental health practices tailored to meet the unique needs of specific cultural populations and communities.

Once implemented it will become clear whether or not a continuum of respite services that use a range of practices will, in fact, improve the delivery of mental health services and whether or not this kind of approach can lead to better and more effective practices. In implementing a continuum of respite options designed by community partners, the County hopes to learn whether interagency and community collaboration can lead to new mental health practices that produce better outcomes, including reduced hospitalization. Community providers have asked for greater input into the design of mental health services; this project provides that opportunity.

EXHIBIT C
(Page 6 of 9)

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: 07/11 – 06/16
MM/YY – MM/YY

This Innovation Project will be for four years and the plan is to implement in phases. However, should opportunities and resources arise that support implementing activities in a later phase sooner, the RPC may consider doing so.

The first phase will be dedicated to Program Implementation and design. It is anticipated that upon approval of the Innovation Plan, the County will enter into a contract with an Administrative Entity to implement the necessary infrastructure to: 1) form the Respite Partnership Collaborative; and 2) establish an administrative process. In addition, an evaluator will be selected in the first phase to ensure a strong evaluation of the project.

In Phase II, the RPC will be fully implemented and have a process in place for selecting respite programs. The evaluation will be developed and regular stakeholder meetings will be convened to report on progress of the Project.

In Phase III, depending on resources and based on what has been learned, there will be a second round of awards made.

In Phase IV, the Evaluation will be in its final stages and the feasibility of replication will be determined. Throughout the project, significant efforts will be directed toward sustainability options should the project be successful.

Phase I: July 2011 – April 2012 Activities:

1. Establish contract with Administrative Entity
2. Administrative Entity establishes Respite Partnership Collaborative; RPC establishes governance and decision-making processes
3. Administrative Entity puts in place contracting and communication processes
4. Administrative Entity hires project evaluator

EXHIBIT C
(Page 7 of 9)

Phase II: May 2012 – June 2012 Activities

1. Respite Partnership Collaborative selects first round of programs
2. Administrative Entity develops contracts/awards and distributes dollars
3. RPC assists in implementation on new program
4. Respite tracking system in place

Phase III: July 2012 – June 2013

1. Based on outcome and resources/ second round of grants
2. Evaluation of RPC process, community engagement and relationship with Administrative Entity
3. Regular Stakeholder meetings

Phase IV: June 2013 – June 2016

1. Evaluation continues
2. Respite Collaborative Partnership meets on a regular basis
3. Quarterly Stakeholder community meetings occur
4. Final Evaluation Report

EXHIBIT C
(Page 8 of 9)

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

As part of this Innovation Plan, an Evaluator will be hired by the Administrative Entity to evaluate all aspects of the project. The Evaluator will work with the RPC to create a logic model to determine how to measure short and long term goals. The Respite Partnership Collaborative will be involved in providing input into the evaluation design and assisting in defining the activities and processes that will measure and evaluate how the RPC will get to their stated goals. There will be many levels to this Project and the Respite Partnership Collaborative will have input all along the way.

Prior to beginning Innovation Planning, a community survey was conducted. One of the questions was: "We want to keep you informed about what we are learning with our Innovation projects. Which THREE way do you think would be most effective?"

The survey listed nine items to rank. Two hundred and eighty seven (287) people responded. The top three responses were: 1) via MHSA emails; 2) via the MHSA website; and 3) via newspaper articles.

All three of these approaches will be utilized in communicating progress and outcomes to the community. Additionally, the Administrative Entity, in collaboration with the RPC, will host regular informational meetings for the community to share progress and to hear input. A communication structure will be formed by the RPC to gather input from the community.

EXHIBIT C
(Page 9 of 9)

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

It is unknown at this time what organization will be selected as the Administrative Entity. Therefore, it is not possible to identify specific leveraging resources; however, it will be an expectation that the entity selected to administer this program will have an infrastructure in place that can be leveraged to facilitate a selection process, award funding and manage contracts. Although efforts will be directed toward sustainability and leveraging, one of the objectives of this Innovation Project is to learn whether a community-driven collaborative approach can lead to the leveraging of new and existing resources to address crisis and support this project in our community.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Sacramento

Work Plan Name

Respite Partnership Collaborative

Annual Number of Clients to Be Served (If Applicable)
TBD Total

Population to Be Served (if applicable):

This project seeks to learn how a collaborative partnership between a county and a non-governmental entity can lead to new partnerships that will leverage new and existing resources and ultimately inform program development, delivery of services and mental health practices in Sacramento County. The second phase seeks to utilize the partnership and community-driven collaborative process to establish crisis respite programs that target all age groups.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

Sacramento County will contract and partner with a community-based organization which will serve as the Administrative Entity for this project. Sacramento seeks to learn whether this partnership can expedite the release of program funding into the community, lead to the leveraging of new and existing resources, and lead to new partnerships that can help address crisis and other mental health issues in our community. Additionally, the County wants to learn whether the formation of a Respite Partnership Collaborative that is community-driven, rather than county-driven, can lead to effective crisis respite programs that serve all age groups in various locations within our community.

EXHIBIT E

Mental Health Services Act
Innovation Funding Request

County: Sacramento Date: 6/21/2011

	Innovation Work Plans		07/11-06/16 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth,	Transition Age Youth	Adult	Older Adult
1	1	Respite Partnership Collaborative	$8,810,600				
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26	Subtotal: Work Plans		$8,810,600	$0	$0	$0	$0
27	Plus County Administration		$0				
28	Plus Optional 10% Operating Reserve		$0				
29	Total MHSA Funds Required for Innovation		$8,810,600				

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Sacramento
Fiscal Year: 09-10, 10-11, 11-12
Work Plan #: 1
Work Plan Name: Respite Partnersh
New Work Plan ☑
Expansion ☐
Months of Operation: 07/11 - 06/16
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures*			8,810,600	$8,810,600
2. Operating Expenditures				$0
3. Non-recurring expenditures				$0
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
Expenditures	**$0**	**$0**	**$8,810,600**	**$8,810,600**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$8,810,600**	**$8,810,600**

*Contract has not yet been awarded; therefore line item expenditures have not been determined

Prepared by: Jane Ann LeBlanc
Date: 6/21/2011
Telephone Number: (916) 875-0188

ATTACHMENT A
Rev 5/13/11

Draft Innovation Plan

Essential Purpose for Innovation: *To promote interagency and community collaboration*

Learning Goal(s): *Can a community-driven collaborative approach lead to new partnerships that can maximize existing resources and establish a continuum of respite services that will reduce mental health crisis? Does this type of collaboration lead to better planning? Will the Respite Partnership Collaborative lead to better coordination of care and new practices that improve the delivery of mental health services?*

Administrative Entity to serve as Administrative and Fiscal Agent

Respite Partnership Collaborative

A collaborative comprised of community partners to develop, provide or support respite options in Sacramento County

- Make recommendations about RPC membership and governance structure
- Participate in regular RPC meetings and community stakeholder meetings
- Establish partnership and networking opportunities with other community resources and MHSA programs
- Explore options for leveraging and sustainability for crisis respite and other innovative options
- Participate in respite program selection process
- Participate in project evaluation
- Develop technology to identify and track respite options in Sacramento County

Each proposed respite program will address the following criteria:

❖ Maximize inclusion of Youth/Peer/Family/Caregivers in employment, volunteer, and leadership opportunities ❖ Peer/Youth/Family/Caregiver Support Services ❖ Culturally responsive traditional healing practices and alternative approaches ❖ Transportation ❖ Located in neighborhood or home-like setting ❖ Voluntary ❖ Trauma Informed Care ❖ Wellness and Recovery Principles ❖ Assessment/linkage/triage

UP TO FIVE POPULATIONS TO BE SERVED

1.	2.	3.	4.	5.
Seriously Emotionally Disturbed Children in crisis Parents need a break	Respite option for a specialized, or cultural or ethnic population	Teens/ TAY in crisis	Adults/Older Adults in Crisis	Adults in Crisis who have dependent children

1

ATTACHMENT A

RESPITE PARTNERSHIP COLLABORATIVE (RPC)

Background: An Innovation Workgroup comprised of diverse stakeholders was established to strategize innovative ideas that can respond to mental health crisis in Sacramento County. Two of five strategies proposed by the Workgroup included some form of respite. All five strategies developed by the Workgroup were presented to the community at large as well as to nine small community groups to elicit feedback and recommendations on ways to enhance the strategies. Input and feedback from the community and the Innovation workgroup was synthesized and is represented in this proposal.

Essential Purpose for Innovation/Learning Goals: The Innovation project that Sacramento County proposes to the Mental Health Services Oversight and Accountability Commission must identify the essential purpose that will address learning and change. In implementing a continuum of respite options designed by community partners, the essential purpose would be to improve interagency and community collaboration. Over the past year, community providers have asked for greater input into the design of mental health services. This proposal provides opportunities for community partners to come together to propose and implement services that could provide a continuum of respite options. DBHS hopes to learn *whether or not a community-driven collaborative approach will lead to new partnerships that can maximize existing resources to establish a continuum of respite services that will reduce mental health crisis.*

Administrative Entity: The model being proposed calls for using a competitive process to select one organization that will serve as the administrative entity for the Innovation project. The complete scope of this administrative organization is still being defined, however, duties may include but not be limited to the following: establish the Respite Partnership Collaborative (RPC); facilitate award selection processes , oversee the distribution of funds and manage contracts; serve as a member of the RPC but not provide respite services; coordinate and work with DBHS to implement the Innovation Project; provide technical assistance to the RPC; host and facilitate meetings; and develop and implement a communication plan and evaluation framework.

Funding: DBHS will request dollars from the Mental Health Services Act (MHSA) Innovation component to fund this RPC Innovation Project. Upon approval and allocation of funding, DBHS will contract with an Administrative entity to implement the project. (Insert approximate funding amount)

Respite Partnership Collaborative: A Respite Partnership Collaborative will be developed to support respite options throughout Sacramento County. The Innovation Workgroup may continue functioning as the interim Collaborative while the RPC is being established. The RPC will develop a governance structure and decision making process that is transparent, inclusive and utilizes the overarching principles established by the Innovation Workgroup. DBHS will provide support to build infrastructure for this collaborative. Membership will be comprised of community groups that have a commitment to the mission of this project, including but not limited to consumers, family members of consumers, representatives of the five populations to be served, mental health agencies, non traditional mental health providers, homeless programs, faith based providers, system partners, cultural brokers/representatives, advocates and other subject matter experts. The RPC will assist in overall coordination, implementation and leveraging of new and existing community resources. Other functions of the RPC will include the following: 1) participate in regular RPC and community stakeholder meetings; 2) establish partnership and networking opportunities with other community resources and MHSA programs, including WET to deliver Trauma Informed Care training; 3) participate in respite program selection process; 4) participate in a RPC Project evaluation; 5) develop technology to identify and track respite options in Sacramento County; and 6) others to be determined.

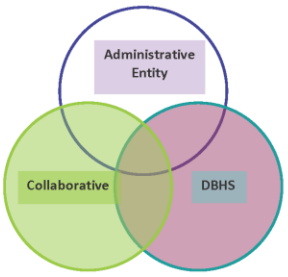
2

Choosing Community Respite Options A process will be developed to ask the community to propose program models that can provide respite options for up to five different target populations. Each respite option must include criteria set forth by the Innovation Plan and address the five areas below. The RPC will establish a selection process, form a selection committee and develop selection criteria. Once awards are made, the administrative organization will develop contracts and distribute funds.

Potential Items to be addressed in applications for a respite program:

1. **TYPE of respite being proposed and why – To include: what staffing will be needed, how will peer and family support be utilized; use of alternative and/or complementary healing approaches; assessment, triage and linkage; transportation options** (Examples, not an exhaustive list)
   - Designated allocation – Example: 40 hours of respite per month for a family with a child having a mental health diagnosis
   - Brief Time Out respite
   - Volunteer respite co-op where families provide respite to one another
   - Peer-Operated Crisis Respite Program – unlocked, voluntary mental health consumer managed crisis residential program
   - Recreational respite – hours of planned recreational respite
   - Hub Model – a designated group receives respite from one Hub family that can provide day, overnight, planned and/or crisis respite
   - Coordinated community-based respite for family caregivers caring for individuals with special needs of all ages; relies on partnerships to build and ensure respite capacity
   - Faith in Action – multi-faith volunteers working to provide in-home care for neighbors with long-term health needs
   - Support Team Network – groups of volunteer organized to pool talents, creativity, time, and leadership to offer more than one volunteer can provide alone
   - Medical Respite – respite care focused on individuals with medical issues
   - Group respite – social adult day care model, 4 hours a week, staffed by paid professional
   - Inter-generational respite using trained college students to provide companionship and services to the frail elderly
   - Respite Center/neighborhood based/culturally specific center
2. **DURATION – amount of time being proposed and why**
3. **METHOD for administering respite – what methods are being proposed and why** (Examples, not an exhaustive list)
   - Respite voucher program – gives individuals/families ability to choose respite provider, become the employer by hiring the respite worker, negotiates the rate of pay and manages and provides some of the training
   - Respite care agency – recruits, trains and recommends licensing of respite care providers
   - Use of motel rooms with monitoring
   - Free standing respite facility
   - Neighborhood home
   - Contracted services to a Board and Care
   - Respite brokerage service for paid and volunteer services
   - Respite consultants – provide short-term respite while working with family to identify and train long-range respite resources
4. **LEVERAGING – What will be leveraged by applicant agency? How will the respite link to existing community resources, including other MHSA programs?**
5. **BUDGET**

Mental Health Services Act
Draft Respite Partnership Collaborative
Roles and Responsibilities



Administrative Entity	Respite Partnership Collaborative (RPC)	Division of Behavioral Health Services (DBHS)
1. Coordinate and partner with DBHS to implement Innovation Plan 2. Establish RPC 3. Host/coordinate and participate in RPC and community meetings 4. Facilitate Respite Program selection process 5. Oversee and manage funding awards 6. Develop and implement evaluation activities to assess progress on learning goals, provide data to RPC, DBHS, and community 7. Develop and implement communication plan (to engage community, share learning)	1. Make recommendations about RPC membership and governance structure 2. Participate in regular RPC meetings and community stakeholder meetings 3. Establish partnership and networking opportunities with other community resources and MHSA programs 4. Explore options for leveraging and sustainability 5. Participate in respite program selection process 6. Participate in project evaluation 7. Develop technology to identify and track respite options in Sacramento County	1. Coordinate/partner with Administrative Entity to implement Innovation Plan 2. Develop criteria for RPC based on Innovation Plan 3. Provide liaison and Technical Assistance to Administrative Entity and RPC and facilitate connections to other Mental Health Services Act programs 4. Participate in RPC 5. Partner with Administrative Entity to develop evaluation framework 6. Monitor contract with Administrative Entity 7. Report results to Department of Mental Health and Oversight and Accountability Commission

ATTACHMENT B

Sacramento County Innovation Workgroup Roster

#	Name	Alternate	Stakeholder Group
1	Mary Ann Bennett	Lisa Bertaccini	DBHS/MHSA Steering Committee
2	Delphine Brody		Consumer Advocate
3	Caroline Caton		Family Advocate/MHSA Steering Committee
4	Ebony Chambers	Ken Borton	Family Advocate
5	Lois Cunningham	Michaele Beebe	Family Advocate/MHSA Steering Committee
6	Clara Evans	Rosemary Younts	Physical Health Provider
7	Patty Gainer	Randy Hicks	Consumer Advocate
8	Michael Hansen	Kathleen Derby	Mental Health Board
9	Marilyn Hillerman	Sherlie Magers	Family Advocate/MHSA Steering Committee
10	Ben Jones		Consumer Advocate/MHSA Steering Committee
11	Dorian Kittrel	Bonnie Cooper-Elsberry	DBHS/MHSA Steering Committee
12	Sandra Marley		Consumer Advocate
13	Jonathan Porteus	Liseanne Wick	Mental Health Provider
14	Stephanie Ramos		Family Advocate/MHSA Steering Committee
15	Marbella Sala		Ethnic Services/MHSA Steering Committee
16	Dave Schroeder		Consumer Advocate/MHSA Steering Committee
17	Stuart Seaborn	Suzanna Gee	Disability Rights CA
18	Frank Topping	E.J. Hullana	Consumer Advocate/MHSA Steering Committee
19	Glen Xiong	Richard Cross	Mental Health Provider
20	Jon Zwolinski		Law Enforcement

Deb Marois Facilitator
Carol Wright Facilitator

01/27/11

ATTACHMENT C

Mental Health Services Act **Innovation Planning Community Participation Overview**	
Community Volunteer Hours – 1,443.50	
Self-Identified Ethnicities	
African American (Black)	Japanese
Apache	Laotian
Arab	Latino/a (Hispanic)
Asian	Mien
Bi-Racial	Multi-Racial
Cambodian	Native American
Chinese	Paiute
Filipino	Puerto Rican
Hmong	Slavic
Hungarian	Scottish
Iranian	Vietnamese
Italian	White
Identified Stakeholder Groups (not inclusive)	
Advocates	Hospital Council
Asian Pacific Counseling Center	Hospitals (Heritage Oaks, UCD)
Consumers	Inter-tribal Council of CA, Inc
Crisis Residential	Lao Family Community Development
Department of Human Assistance	Law Enforcement
Department of Health and Human Services	LGBTQ
Disability Rights CA	Mental Health America of Northern CA
Division of Behavioral Health Services	Mental Health Providers (multiple)
Education	MHSA Steering Committee
Faith-based (multiple)	Transition-Age Youth
Family Members	The Gardens
Gender Health Center	

ATTACHMENT D

Sacramento County MHSA Innovation Workgroup Orientation Meeting Summary

January 12, 2011, 3:00 – 6:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

Goals for Meeting

- Understand MHSA and Innovation from State perspective
- Become familiar with the Innovation collaborative planning process, goals and timeline
- Understand roles and responsibilities of workgroup, DBHS staff and facilitation team
- Begin to build relationships among workgroup members
- Review outcomes of Innovation Kickoff
- Introduce sources of existing data and identify additional data needs

I. Welcome & Introductions

Michelle Callejas, MHSA Program Manager, Division of Behavioral Health Services welcomed the Innovation Workgroup members and members of the public. Deb Marois, Innovation Planning Project Consultant from Marois Consulting & Research, and her co-facilitator, Carol Wright, reviewed the ground rules introduced and accepted at the Kickoff. They noted that these would be used at future Innovation meetings.

The facilitation team also reviewed the parameters for public comment and informed Workgroup members and the public that there would be opportunities for public participation throughout the meeting and time for public comment at the end.

Innovation Workgroup members were asked to complete the "Who's in the Room?" form to identify members' affiliations and interests. Information from these forms will be compiled and presented at the January 21 meeting.

Innovation Workgroup members and the public were then paired up to introduce each other, their affiliation, and the gift that they bring to the Innovation Planning Process. Gifts that Innovation Workgroup members bring include attentiveness, lived experience, passion, knowledge, grounded, empathy, attention to detail, communication, inclusiveness, openness and patience. Reviewing the ground rules and acknowledging the gifts that members bring to this collaboration built a strong foundation for this planning process.

II. Mental Health Innovation in California

Wanda Kato and Vivian Lee, members of the MHSA Oversight and Accountability Commission (OAC) provided an overview of the OAC's role in the Innovation component and reviewed the "Innovation Work Plan Success Top Ten List," included in Workgroup binder materials. Additionally, Ms. Kato distributed a compilation of other counties approved Innovation Projects.

Key points included:

- OAC has approval authority for all Innovation Work Plans
- Top ten tips for developing a successful Innovation Work Plan
- Definition of Reversion
- Importance of developing a "specific learning goal" verses focusing on service provision
- Avoiding duplication of any Innovation project that other California counties are currently implementing

III. Overview of Collaborative Planning Process and Workgroup Orientation

Before launching in the overview of the Workgroup charge, the facilitation team first asked Innovation Workgroup members to reflect upon a time that they were part of a group or team that worked well together. The elements that make for a successful collaboration from Workgroup members past experience include: having a shared vision; working hard to listen; communication and trust; sticking to timelines; allowing each member to maximize skills; appreciated differences and diversity; building on cultural differences and gifts; having mutual respect for voices; being patient.

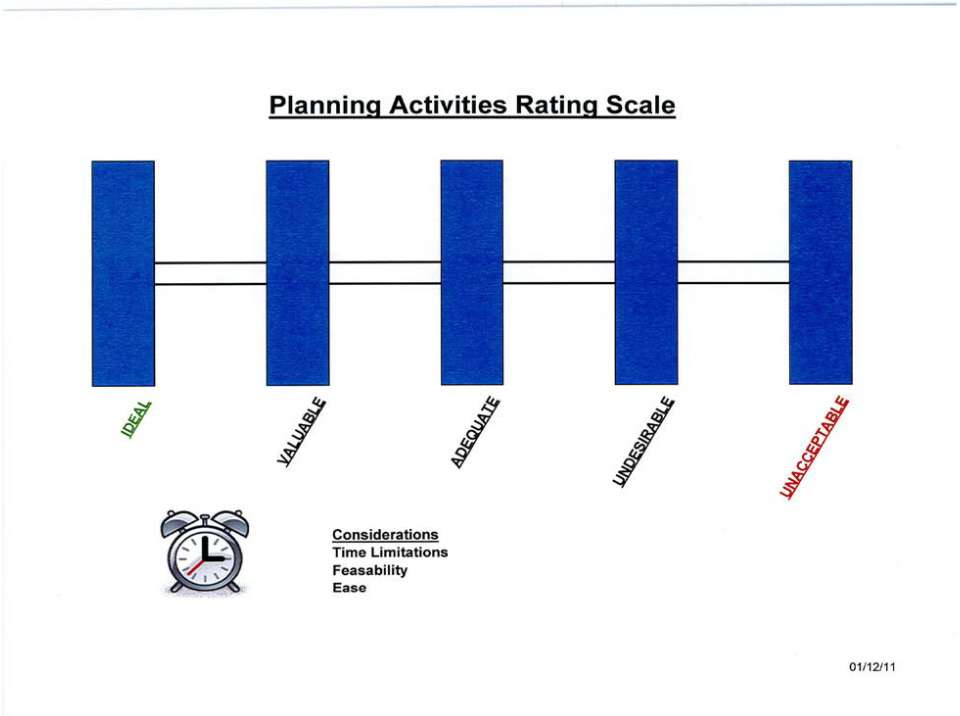
The facilitation team reviewed other elements of a collaborative planning process and provided an orientation to the planning process. Presentation highlights included: frequent sources of conflict in collaborative planning, conflict management, Sacramento County MHSA Innovation Workgroup Charge, Workgroup and Community Meeting schedule.

Work Toward Consensus

The facilitation team introduced the concept of consensus as a fundamental principle in the decision making process. Some Workgroup members asked questions about voting and the structure of the Workgroup. A few members expressed the desire for Workgroup co-chairs and adoption of Robert's Rules in order to make motions. Concerns were expressed regarding the need for transparency and to ensure all information is provided. Examples of past issues were voiced, especially the System Integration Workgroup. Facilitators used this example to

demonstrate the principle of focusing on issues rather than positions. A position is "We want co-chairs." An underlying concern that can be met multiple ways is, "We want a fair, inclusive and transparent process." Facilitators also explained that voting can result in a 51% majority "winning" and a 49% minority "losing." In complex issues that require collaboration of multiple stakeholders in an advisory capacity, recommendations that have the most consensus carry more weight. For issues where the group can not reach consensus, the Division requests multiple options be included for the consideration of the full MHSA Steering Committee. The facilitation team further explained that the group will only meet four times to develop its recommendations and facilitators will serve as a communication channel for issues members want to raise for the whole group, a role typically fulfilled by co-chairs. Facilitators requested follow up discussions with members who continue to have concerns about the need for co-chairs.

The "Planning Activities Rating Scale" was introduced to assist in evaluating suggestions made for the Innovation planning process. When suggestions are generated, members are asked to consider where it falls on the scale and to consider factors such as time, feasibility, and available resources. Some suggestions, while ideal, will not be able to be implemented given time and resources available. Members agreed that any suggestion that is rated as ideal, valuable or adequate would be considered.



The definition of consensus: Consensus means that all group members agree that they can live with a decision.

"Levels of Agreement" is a tool that will assist with consensus building among members of a collaborative. Members may hold different levels of agreement along a six-point continuum that range from strong agreement to strong disagreement. In between are levels whereby members may express disagreement without stopping progress in allowing a recommendation to move forward. Unlike Roberts Rules, collaborative members avoid the sense of winning and loosing and can work towards solutions that result in greater consensus. The facilitators guided Innovation Workgroup members and members of the public through a "Level of Agreement" exercise so that they could experience consensus building.

As a practice question, the group responded to the question: **Do you agree to recommend to DBHS to allow Innovation Funds to revert to the State?** At the conclusion of the exercise, all participants reached consensus to move forward with the Innovation planning process.

1	2	3	4	5	6
Strong Agreement	**Agreement with Minor Concern**	**Agreement with Reservations**	**Stand Aside**	**Disagreement with Major Concern**	**Strong Disagreement**
I support the proposal	*Basically, I support the proposal.*	*I can live with it*	*I don't like this, but I don't want to hold up the group*	*I don't want to stop the proposal, but I have serious concerns.*	*I do not support this proposal*

1-5 means that the member supports the proposal and constitutes consensus.
Only"6" represents a divergent opinion.

IV. Introduction to Existing Data

Lisa Sabillo, Research Evaluation Performance Outcomes (REPO) Planner, introduced the data sources that will be presented at the next Innovation Workgroup meeting. Existing Data from previous MHSA Community Planning Processes, Innovation Survey and other relevant community data related to crisis will be reviewed.

Innovation Workgroup members were asked for suggestions of other data that is important and necessary for this planning process. The following is a list of additional data sources that member suggested: Sacramento County suicide rates, Suicide Prevention Crisis Line, Crisis Residential Programs, effectiveness of Turning Point Crisis Residential Program, Mental Health Planning Council, AB2034, System Integration Workgroup recommendations, Loaves and Fishes data related to deaths and suicide, Sacramento Steps Forward, unemployment, homelessness, domestic violence, police and sheriff's data, Mental Health Treatment Center Crisis Residential data, private psychiatric hospital data, demographics on various cultures, who gets served in a crisis, homelessness due to mental illness, Sacramento County Access Team data, school and other community agencies data related to crisis, California Department of Public Health data on

suicide prevention, incarceration due to untreated mental illness, grief support groups, rape crisis line data, hospital ER visits, Office of Rehabilitation, Community Colleges Office of Disability.

V. Public Comment

A member of the public encouraged the Workgroup to consider how to leverage funds to increase employment for mental health consumers and their families by exploring greater collaboration with Community Colleges and the Department of Rehabilitation.

VI. Next Steps and Meeting Evaluation

Innovation Workgroup members and members of the public were invited to submit written comments to evaluate the meeting. Innovation workgroup members also provided verbal feedback about the meeting. What the Workgroup members regarded as positive included: the introduction exercise, timelines and dates, reiterating and reviewing ground rules, good organization, inclusiveness, positive energy. Changes or improvements for the meeting that the Workgroup members suggested included: develop electronic collaboration process; concerns were not addressed or not adequately addressed; focus on the past and not adhering to the ground rule of being future focused; smaller tables are preferred; lack of participatory exercises; tension needs to be channeled in a positive way.

Innovation Workgroup members were given homework assignments in preparation for the next meeting:

- Review contents of their Innovation Workgroup binders
- Reminder to bring the binder to each meeting
- Provide needed data to DBHS staff by Tuesday, January 18
- Think about how you will communicate with your constituencies about the Innovation Planning Process
- If desired, appoint an alternate and provide contact information to DBHS.

The next Innovation Workgroup meeting is on Friday, January 21, 9am 5pm.

Sacramento County MHSA Innovation Workgroup Meeting #1
Meeting Summary
January 21, 2011, 9:00 am – 5:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

Goals

- Identify innovative ideas for community engagement in Innovation planning.
- Review and discuss data, existing plans and ideas to better understand mental health crisis and response.
- Identify barriers to resolving issues of response to crisis and alternatives to hospitalization.
- Identify assets and potential opportunities to address crisis response and alternatives to hospitalization.
- Begin to define crisis for the purposes of Innovation Planning.
- Prioritize draft learning goals for the Innovation plan recommendations.
- Strengthen the foundation of trust among Innovation Workgroup team members.

I. WELCOME & INTRODUCTIONS

Welcome and Introductory remarks were made by Michelle Callejas, MHSA Program Manager. Deb Marois, Innovation Planning facilitator, introduced Carol Wright, co-facilitator, and Greg Gollaher, Graphic Illustrator. A PowerPoint presentation (see PowerPoint handout) highlighted the meeting summary purpose, review of the planning process and ground rules. The concepts of a straw poll and "dotocracy" were introduced as ways to test ideas. Going around the room, workgroup members introduced themselves, their affiliation and were asked to name ***one thing that helps build trust or one reason to have group ground rules***. The Workgroup members came up with the following: honesty, common interest/goals, staying positive, assume that everyone has good intent, being on the same page/expectations, open and honest communication, integrity, working together towards one goal, input, transparency, and acknowledgement that we all have value.

Sacramento County MHSA Innovation Workgroup Meeting #1
Meeting Summary
January 21, 2011, 9:00 am – 5:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

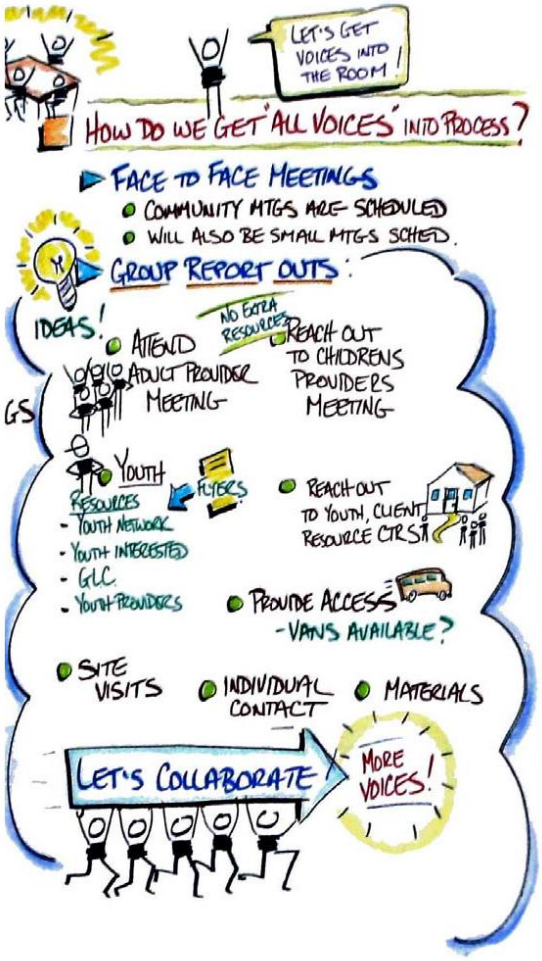
II. Engaging Community Members in Innovation Planning

From the January 12, 2011 Innovation Orientation Meeting "Who's in the Room" exercise, Workgroup members identified their employer or volunteer affiliations and the constituency groups they represent. That information was presented as a graph to inform the Workgroup about what voices are and are not represented in the room (see "Who's in the Room" handouts).

The facilitators led the Workgroup members in a discussion regarding how to ensure that missing voices are included in planning and ways to increase community engagement.

In small groups, Workgroup members were asked to brainstorm how to fulfill the responsibility of representing others in the Innovation Planning process. Each small group reported back to the large group an innovative idea, who will do it, the resources needed, and next steps.

Sacramento County MHSA Innovation Workgroup Meeting #1
Meeting Summary
January 21, 2011, 9:00 am – 5:00 pm
7001-A East Parkway, Sacramento, CA 95823 Conference Room 1



Other ideas that were generated included: developing fliers, providing transportation to meetings, other locations for additional Community Input meetings, getting clients in acute or residential settings to meetings, utilizing websites and Facebook, email distributions, site visits to service agencies, youth advisory groups, youth advocates recruiting other youth, community and cultural resource centers. The members of the public offered the following ideas: Public PSAs; television; ads in newspapers; advertise in grocery stores, laundromats, and welfare and county offices; identify specific goals and questions prior to doing outreach; ensure inclusion of working-class families who do not have Medi-Cal coverage.

Carol Wright reminded everyone that the Community Input meetings are scheduled for March 5 and March 8. She asked members to think of ways to get their constituents to these meetings. Additionally, several Workgroup members volunteered to collaborate with the DBHS Cultural Competence Committee on reaching out and engaging unserved and underserved communities to participate.

Sacramento County MHSA Innovation Workgroup Meeting #1
Meeting Summary
January 21, 2011, 9:00 am – 5:00 pm
7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

III. Overview of MHSA Planning Data

Deb Marois shared insights from Stakeholder Interviews conducted by the facilitators prior to Workgroup meetings (see Stakeholder Interviews handout). The interviews were conducted to gain background and learn about any underlying issues that might influence the Innovation planning process. Deb reviewed a summary of strengths, challenges, and advice from the stakeholders. The design for the Innovation planning process is, in part, based on feedback from the interviews, with an emphasis on ensuring transparency and comprehensiveness. It was acknowledged that previous community engagement processes have been perceived as challenged; however, it was also acknowledged that relationships are improving.

ATTACHMENT E

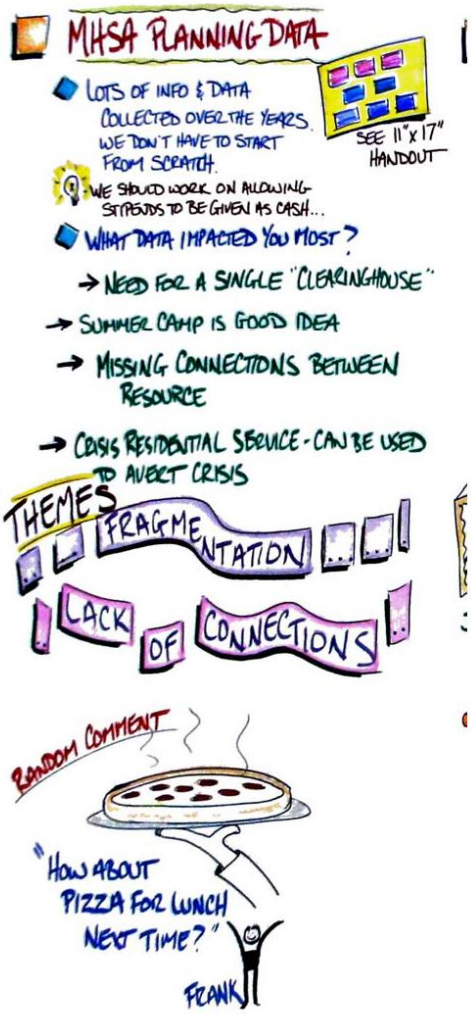
Sacramento County MHSA Innovation Workgroup Meeting #1
Meeting Summary
January 21, 2011, 9:00 am – 5:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

Crisis and Innovation In Sacramento County: What Does The Data Say?

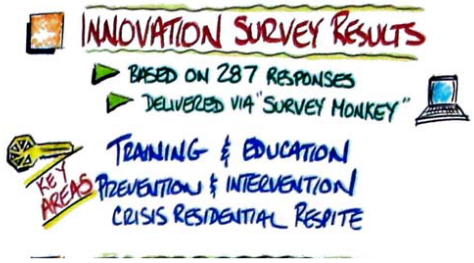
MHSA Planning Processes: Michelle Callejas provided an overview of the previous community planning processes that were part of the three MHSA components: Community Services and Supports (CSS), Workforce Education and Training (WET), and Prevention and Early Intervention (PEI) (see MHSA Community Planning Process handouts). She explained that each planning process identified themes, ideas and issues, many of which had a relationship to crisis, either before a crisis occurs, the actual crisis or after a crisis has happened. Some of the themes ideas or issues identified in the planning process resulted in funded community programs. Those that were not funded were provided to the workgroup as ideas to think about as we move forward.

Workgroup members were asked to think about what information impacted them the most. They listed the following: need for "Clearinghouses" that are linked to each other, Summer Camp, disappointment that MHSA Components were not connected to each other, lack of connections with dually diagnosed, many of the post-crisis ideas could be moved to pre-crisis ideas, many ideas can fit in multiple boxes.



Sacramento County MHSA Innovation Workgroup Meeting #1
Meeting Summary
January 21, 2011, 9:00 am – 5:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1



Crisis Statistics: Lisa Sabillo, Program Planner with DBHS Research, Evaluation, Performance Outcomes Unit (REPO), provided an overview of data used by DBHS in trying to understand the current state of crisis in Sacramento County. The data included most of the sources requested by the Workgroup during the Orientation meeting (see Crisis in Sacramento County and Crisis in the Community handouts).

Innovation Survey: Lisa then summarized Innovation Survey results. Over 280 people responded to the survey (see MHSA Innovation Survey handout). The survey revealed three primary areas that were important to respondents, in addition to crisis: Training and Education, Prevention and Intervention Services, and Crisis Respite and Crisis Residential Services.

Throughout the survey, the following themes were frequently mentioned: 24/7 services, accessible services, collaboration with partners (peers, law enforcement, education, CPS, other system partners), culturally specific services, peer run services, services along the crisis continuum. Survey participants wanted to learn effective strategies for preventing crisis, types of supports needed to prevent crisis, how training and education can support the community in providing prevention and crisis services, how to collaborate with others to provide culturally relevant services, how to provide accessible treatment, how to provide cost effective and peer run services.

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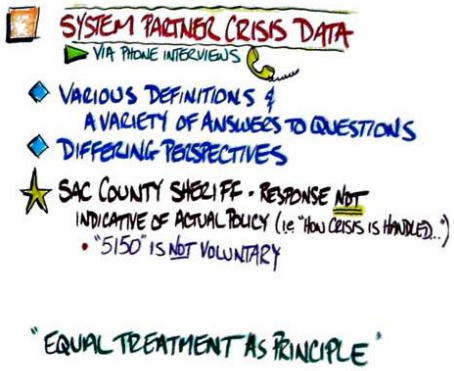
System Partners Perspective: In an attempt to learn how crisis is defined in other systems, DBHS interviewed system partners asking for their perspective on crisis. Input was shared with the Workgroup members (see System Partners handout).



Deb reminded Workgroup members not to jump to conclusions about the data but to carefully consider the information presented. She encouraged members to listen for and focus on what they were interested in learning.

In small groups, Workgroup members were asked to reflect on the data and to think about the following:

What picture does the data paint of crisis in Sacramento County? What stands out? What insights or connections occurred to you? What questions does it raise? Workgroup members reported the following: (See illustration to the right).

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The Workgroup members identified words that jumped out or missing words that define crisis. (See illustration to left).

A number of Workgroup members volunteered to form a subcommittee to draft a definition of crisis. They will bring the draft definition back to Workgroup Meeting #2.

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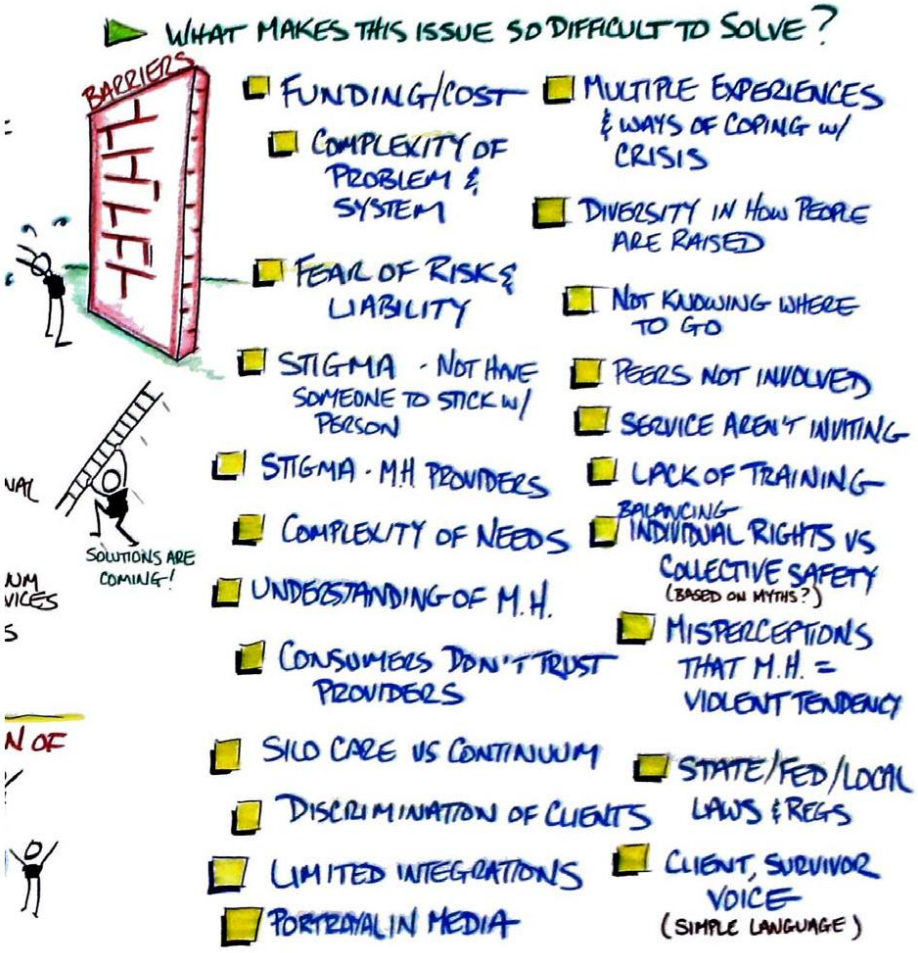
In small groups, Workgroup members identified why the issue of crisis is so difficult to solve. Before reporting their results, Deb cautioned the Workgroup that focusing on barriers can make the challenges seem overwhelming and that it can be more effective to build on assets. Workgroup members identified the following barriers:



ATTACHMENT E

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PANEL: CONTEXT FOR INNOVATIVE PLANNING

Presenters were asked to provide a brief overview of concepts and ideas raised by the stakeholder interviews. This information is intended to provide background and context to Workgroup members as they develop their recommendations.

Clara Evans, Catholic Health Care West Policy Director, presented on the Hospital Council Plan: The Hospital Council was established in response to the influx of mental health consumers in local hospital emergency departments. The Hospital Council membership is comprised of community providers, partners, consumers and family members whose goal is to address how we can all work together to ameliorate crises and to collaboratively take care of people in crisis. Their work started in March 2010 and recommendations were developed by July 2010. Clara reviewed the "Sacramento County Behavioral Health System Redesign Recommendations" and charge of each workgroup (see Draft Sacramento County Behavioral Health System Redesign Recommendations handout).

Delphine Brody, California Network of Mental Health Clients MHSA Public Policy Director, presented on Peer Run Services: Delphine Brody briefly described the handouts about peer-run services included in Workgroup members meeting packet. She provided an overview of peer-run services and discussed how involuntary holds in a locked facility can cause more harm than good, the positive outcomes of peer-run crisis respite services, and model programs. California Network of Mental Health Clients would like to see more peer-run MHSA funded programs (see Peer-Run Crisis Alternatives PowerPoint and peer-run model articles).

Mary Ann Bennett, DBHS Deputy Director, presented on Sacramento County's Vision for Crisis Services: In establishing a framework for a vision for the community, Mary Ann emphasized that government, including DBHS, is part of the community and that we all need to work together on solutions. The vision is inclusive of peers/consumers, family members and culturally competent providers and incorporates a safe and trusting environment for everyone. The vision is a continuum of services available for people at all phases of their recovery. There are three levels of services on the continuum: pre-crisis/prevention; crisis; and post-crisis. Peer support is envisioned throughout all levels to help consumers navigate the system. She also discussed the hopes of changing the culture and environment of the Sacramento County Mental Health Treatment Center campus and discussed the opportunity to leverage existing space that is paid for by DBHS but is not being utilized.

Michelle Callejas, MHSA Program Manager, presented on the Innovation Budget data: Michelle Callejas reviewed the Innovation Component Budget and explained reversion issues in FY 2011/2012 and the projected drop in funding in FY 12/13 (see Innovation Funding handout). It

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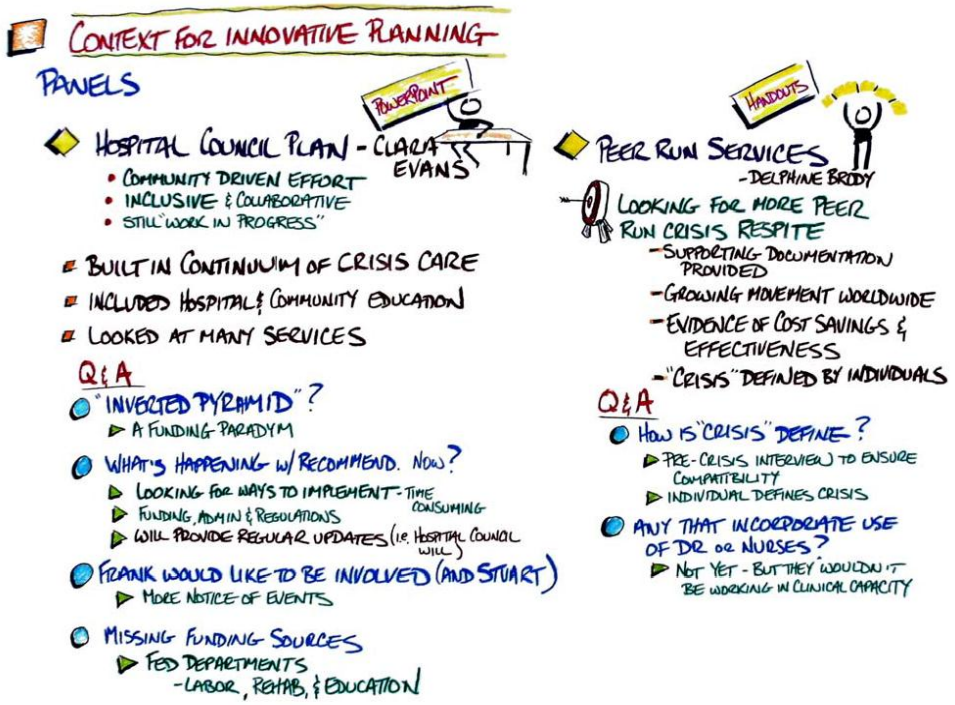
will be important for Workgroup members to consider what we want to learn in the next three years, costs involved in implementation, and sustainability.

The following graphics reflect the presentations by Clara Evans and Delphine Brody.



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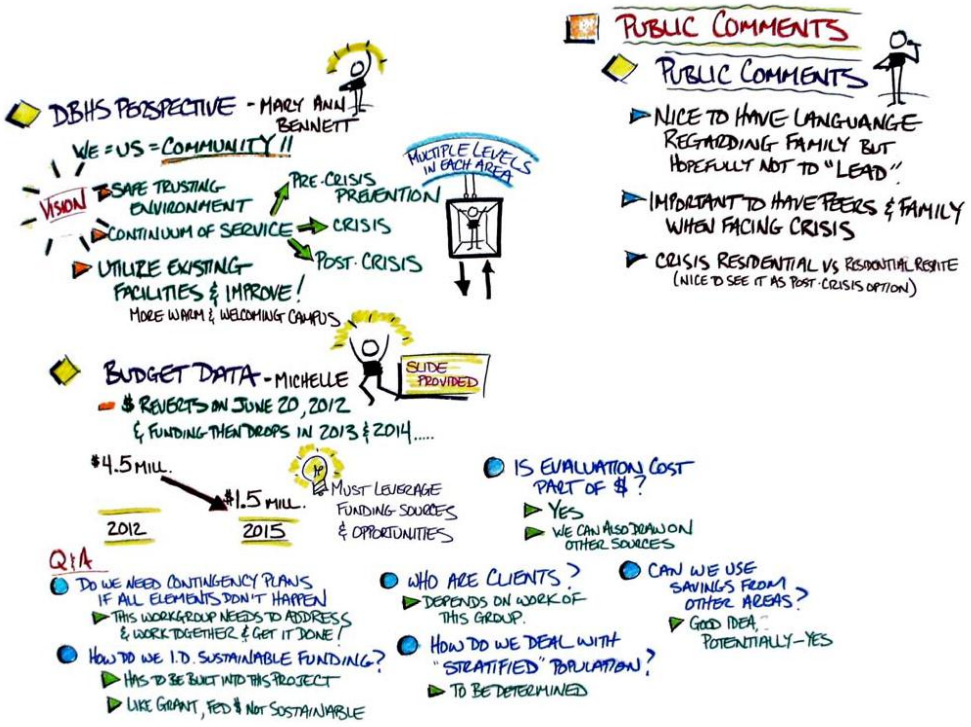
The following graphics reflect the presentations by Mary Ann Bennett and Michelle Callejas.



IV: Learning: The Heart of Innovation

Workgroup members worked in small groups to review the list of Innovation learning goals identified at the Kickoff and Orientation. Members were asked to consider if any learning goals needed to be added and then come to consensus in the small group to prioritize them. Members of the public also formed a small group and participated in the exercise. No new goals were added, though Workgroup members suggested rewording some. The results in order of support are as follows:

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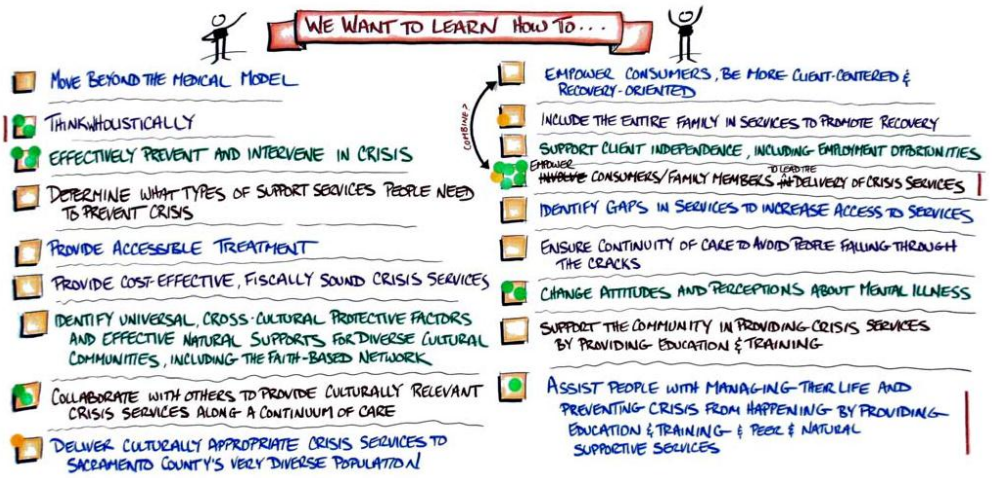
- ☐ Empower consumers/family members to lead the deliver of crisis services that are more client-centered and recovery-oriented
- ☐ Effectively prevent and intervene in crisis
- ☐ Collaborate with others to provide culturally relevant crisis services along a continuum of care
- ☐ Think "wholistically"
- ☐ Change attitudes and perceptions about mental illness
- ☐ Assist people with managing their life and preventing crisis from happening by providing education and training



V. Public Comment

Members of the public offered the following:

- Are there any existing services for any population group that are less effective than existing models of services for that group? If so, can those existing services be replaced/transformed?
- Need training and awareness of the consumer experience and how that translates to more effective services

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- Challenge of balancing individual rights/right to self-determination verses collective rights of safety
- Data might suggest learning goals of which crisis services are effective verses non-effective
- Stigma that peer involvement is not to be trusted, therefore, not seeing the obvious solutions that peers need to be involved at every level to increase empathy, effectiveness of services. Services that would be inviting, that would be freely chosen by individuals prior to crisis and also chosen by individuals in crisis. Needs to be training within the system toward understanding of this type of expertise and how it translates to more effective services.
- Crisis: Equalization and participation on getting better

VI. Next Steps

- Innovation Workgroup Meeting #2: February 10, 2010, 9am – 5pm. Review data and arrive prepared to develop draft strategies to achieve learning goals.
- Crisis Definition Subcommittee will bring a definition back to Workgroup Meeting #2.
- Workgroup members who are interested in working on community outreach and engagement will contact Carol Wright or Julie Leung.
- In response to discussion following the panel presentations, a schedule to tour the Sacramento County Mental Health Treatment Center will be emailed to Workgroup members.
- Catch-up Alternate members before Workgroup Meeting #2.
- Keep constituencies informed of Workgroup progress and send "save the date" notices for community meetings in March.
- Send any correspondence to InnovationWorkgroup@SacCounty.net

Sacramento County MHSA Innovation Workgroup Meeting #2
Meeting Summary
February 10, 2011, 9:00 am – 5:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

Goals

- Create draft strategies to achieve learning goals.
- Adopt a draft definition of crisis.
- Review strategies for community engagement.
- Strengthen the foundation of trust among Innovation Workgroup team members.

I. WELCOME & INTRODUCTIONS

Welcome and opening remarks were made by Michelle Callejas, MHSA Program Manager. Deb Marois, Innovation Planning facilitator, re-introduced Carol Wright, co-facilitator, and Greg Gollaher, Graphic Illustrator. Deb reviewed the agenda and group rules. Going around the room, workgroup members introduced themselves and were asked to share one word to describe how they feel about the progress of the Innovation planning process and the focus on crisis at this time.

Deb reviewed highlights from the January 21, 2011 meeting which included

- A review of the previous Sacramento County MHSA Community Planning Processes
- An overview of the current state of crisis in Sacramento County through data
- Innovation Survey results
- System Partners Perspective on Crisis
- Panel of presenters:

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- Clara Evans who presented the Community Mental Health Partnership Plan
- Delphine Brody who presented on Peer-Run Services
- Mary Ann Bennett who presented Sacramento County's Vision for Crisis Services
- Michelle Callejas who presented Sacramento County's MHSA Innovation Budget

Deb acknowledged Susanna Gee for sending workgroup members the Innovation plans of Los Angeles and Trinity County. Those plans included a peer run model of crisis services. In response to the data and panel presentations, Workgroup members were invited to tour the Sacramento County Mental Health Treatment Center. Workgroup member Delphine Brody subsequently coordinated a Turning Point Crisis Residential Program Tour for Workgroup members. Both Deb and Carol reminded the Workgroup members that the coordination of data and panel presentations and facility tours were in response to Workgroup member questions and requests with the purpose of informing the decision-making process.

The Workgroup members provided the following feedback related to both the Turning Point Crisis Residential Program and the Sacramento County Mental Health Treatment Center Tours:

II. DEFINING CRISIS

A number of Workgroup members formed a subcommittee to draft a definition of crisis. The definition was reviewed along with an overview of their process in developing the draft definition. The Workgroup members were asked to review the proposed definition and propose new language as needed.

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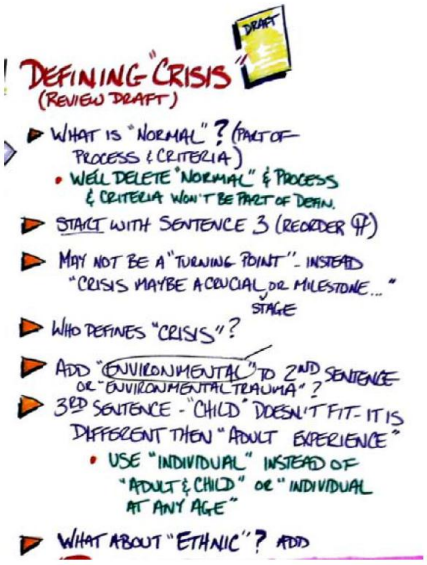

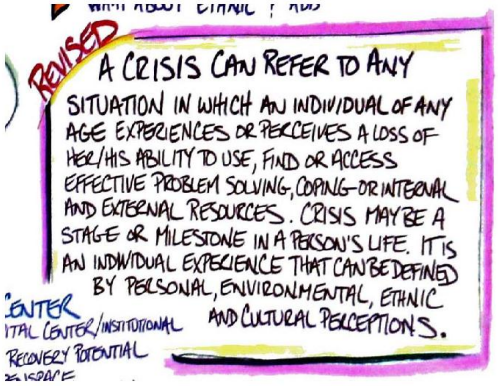

III. A Framework for Innovation

To help Workgroup members build a framework for the Innovation plan, Deb introduced considerations for strategy development and the concept of avoiding either/or thinking but rather to focus on the possibility of integrating ideas. She also reviewed both the Spectrum of Prevention and Strategy Circle concepts which promote the idea of developing multiple strategies at multiple levels and that overlap. (See Considerations for Strategy Development, Spectrum of Prevention, and Strategy Circle handouts). Deb then facilitated a visioning exercise that asked Workgroup members to imagine themselves five years from now where everything that the Workgroup wanted to learn in 2011 had been accomplished. How is life better for consumers, children and families who experience a mental health crisis?

Strategy Development: Workgroup members, individually and then in small groups, began brainstorming Innovative ideas to bring to the larger group that answered the key question: How can we learn more about how to address crisis and alternative to hospitalization in Sacramento County? Susanna Gee, Innovation Workgroup member presented language from Title 9 of the California Code of Regulations, Section 1810.208 that defines "under Medi-Cal

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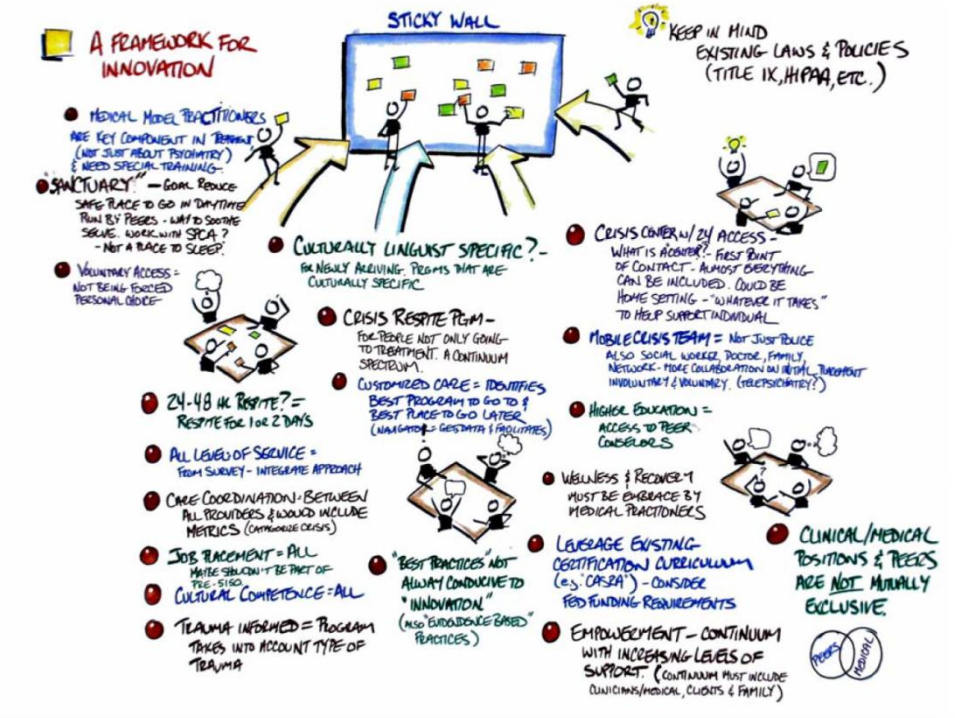
that crisis residential services means therapeutic or rehabilitative services provided in a non-institutional residential setting. Each small group first identified their most critical idea. Second, each group shared their most innovative idea. Groups then contributed an additional idea followed by an emerging idea. All ideas were clustered. Small groups then created names that represented a strategy describing all ideas within each cluster.



To shape and form each strategy, Workgroup members were assigned to a strategy to answer the following questions:

- What will be different as a result of implementing this strategy?
- What existing assets or opportunities can be tapped or combined to leverage resources for this strategy?
- What partners could help carry out this strategy?

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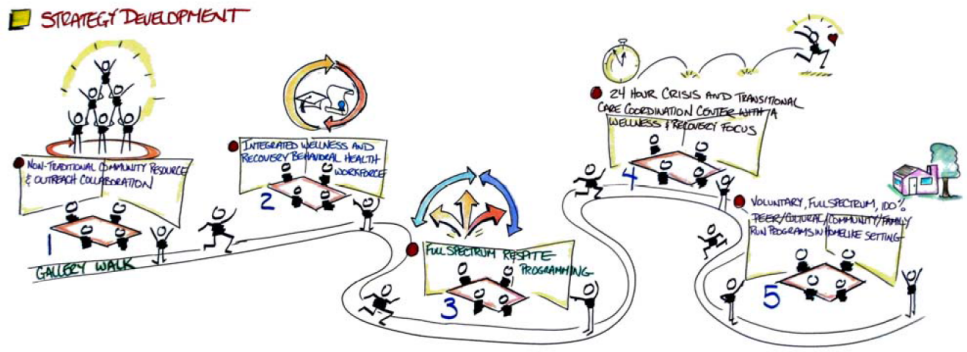
- What primary barriers will need to be overcome to implement this strategy? (See draft Innovation Workgroup Strategies handouts)

Gallery Walk: Workgroup members and the public visited all strategy areas to view the work completed and add additional comments. Using post-it notes, participants answered the following questions:

- What are the strengths of the strategy?
- What questions or concerns do you have?
- What ideas would strengthen the strategy?



IV. Community Meetings

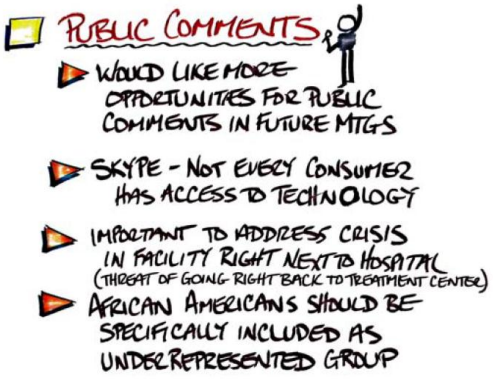
The Workgroup members were reminded of their role of being ambassadors to their constituents and to take steps to encourage their constituents to attend and participate at the Community Input Meetings.

Julie Leung, MHSA Program Coordinator, and Stephanie Ramos, Innovation Workgroup Member, updated Workgroup members about the results of the Innovation Community Engagement Meeting on February 1. Several members of both the Innovation Workgroup and Sacramento County Cultural Competence participated and generated concrete ideas related to encouraging their respective community members to attend and participate in the larger Community Input Meetings. Also, several participants representing local community based organizations agreed to host and facilitate smaller Community Input Meetings for members of

diverse communities who experience language barriers and are more comfortable in a smaller group setting.

V. Public Comment

Members of the public offered the following:



VI. Next Steps

Workgroup members were reminded of the following:

- Consider attending at least one upcoming Community Input Meeting:
  - Saturday, March 5, 2011, 10am – 2pm, Department of Human Assistance, 2700 Fulton Avenue, Sacramento **OR**
  - Tuesday, March 8, 2011, 5:30 – 9:00pm, Samuel Pannell Community Center, 2450 Meadowview Road, Sacramento
- Keep constituencies informed of Workgroup progress and send "Save the Date" notices for community meetings on March 5 and March 8. Encourage your constituencies to participate!
- Innovation Workgroup Meeting #3: March 30, 2011, 9am – 5pm, Voter Registration, 7000 65th Street, Sacramento. Review draft strategies/recommendations.
- Provide updates to Alternate members before Workgroup Meeting #3.
- Send any correspondence to InnovationWorkgroup@SacCounty.net

Mental Health Services Act – Innovation Workgroup: Draft Strategy Recommendations

Rev 03/03/11

ATTACHMENT G

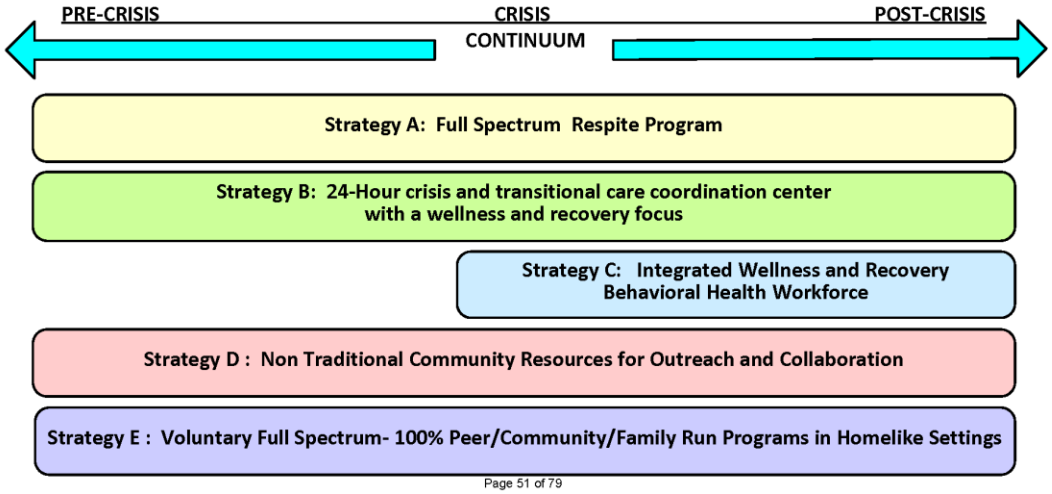
Mental Health CRISIS: can refer to any situation in which an individual of any age experiences or perceives a loss of her/his ability to use, find or access effective problem solving, coping, or internal and external resources. CRISIS may be a stage or milestone in a person's life. It is an individual experience that can be defined by personal, environmental, ethnic and cultural perceptions.
(Adopted by Innovation Workgroup on 02/10/11)

Over-arching Principles Related to Strategies

a) Voluntary access
b) Questioning "best practice"
c) Enhance dignity through alternative to acute care
d) Foster resilience, resourcefulness, personal and social responsibility
e) Integrated approach to care at all levels of service
f) Clinical and peer staff are not mutually exclusive
g) Data collection at intake to find cause of crisis
h) Data collection post-crisis (what worked, what didn't)

Learning Goals

a) Empower consumers/family members to lead the delivery of crisis services that are more client-centered and recovery-oriented
b) Effectively prevent and intervene in crisis
c) Collaborate with others to provide culturally relevant crisis services along a continuum of care
d) Think "Wholistically"
e) Change attitudes and perceptions about mental illness
f) Assist people with managing their life and preventing crisis from happening by providing education and training



Sacramento County Mental Health Services Act
Innovation Community Input Meetings
Summary & Data

Mental Health Services Act
Innovation Community Input Meetings Summary

Background:

At the February 10, 2011, Innovation Workgroup meeting, five strategies were developed to address crisis in Sacramento County. The five strategies developed by the Innovation Workgroup were presented to the community for input during the first two weeks of Match, 2011. To solicit diverse viewpoints, Innovation Workgroup members partnered with the DBHS Cultural Competence Committee to identify organizations interested in hosting small group meetings. The following table is an overview of two large Community meetings facilitated by County and nine smaller community meetings facilitated by host agencies through Sacramento.

Focus	Host Agency	Date	Number of Participants (including facilitators)
Community at large	Division of Behavioral Health Services	3/5/2011	26
Latino	La Familia	3/7/2011	48
Mien	Lao Family Community Development	3/7/2011	13
Native American	Sacramento Native American Health Center	3/7/2011	18
Youth / Transition Age Youth	Stanford Home	3/7/2011	11
Community at large	Division of Behavioral Health Services	3/8/2011	34
African American	The Gardens	3/9/2011	7

Focus	Host Agency	Date	Number of Participants (including facilitators)
LGBTQ	Mental Health America of Northern California	3/9/2011	9
Cantonese, Hmong, Vietnamese	Asian Pacific Community Counseling	3/10/2011	8
Hmong	Asian Pacific Community Counseling	3/10/2011	9
Cantonese	Asian Pacific Community Counseling	3/9/2011	6
Muslim	Muslim American Society of the Sacramento Region	3/12/2011	6
		TOTAL	**169**

Summary of what the community said about crisis:

The following summary is intended to capture the main themes and ideas of three questions asked in the two (2) Innovation Large Community Groups and nine (9) Innovation Small Group meetings held in March 2011: What or who helped the most? What might have helped to prevent a crisis? What would have helped after the crisis?

What or who helped the most?

Being able to turn to family and friends and having a support system in place including neighbors and community was a dominant theme throughout all of the community meetings.

Cultivating self help skills and the ability to use them when feeling stressed was another theme. Learning to understand individual feelings and knowing when to ask for help if things become too challenging, being able to use coping strategies like listening to music, watching funny movies, gardening or playing with pets were mentioned

Connecting with mental health and other health professionals including primary care doctors, emergency room nurses, personal service coordinators, psychiatrists, and therapists was mentioned many times. Working with family and peers advocates as well as

being able to advocate for yourself was also helpful. Accessing community services like Turning Point's Crisis Residential Program or Loaves & Fishes, Crestwood, day program, adhering to a 12-step program and taking medications.

Turning to one's own personal faith or religion was cited as being helpful as well as going to a mosque, church or synagogue. Law enforcement was also helpful for some, especially when in situation where someone may be considered dangerous to self or others.

Some small groups focused more on what did not help including: having non-English speaking therapists or police that responding to a crisis call but not taking the person in crisis in for help, leaving the family terrorized.

What might have helped to prevent a crisis?

Many of the things that participants identified in the section above were also things that might have helped prevent a crisis. Things that were not listed include: transportation, access to community centers or other safe places to go to with 24/7 options, the ability to get immediate response for a mental health condition that is leading to a crisis, language specific 24/7 hotlines, daily rituals to maintain wellness, employee assistance programs (EAP) at work, having a Wellness and Recovery, Relapse prevention training, detoxification programs, linkages to services, integration of physical and mental health and housing supports

A theme of safety came up with idea of self defense courses and tools for protection such as pepper spray. Opportunities to release frustration included punching bags in different locations in the community

Smaller groups emphasized the need to have increased language capacity where services are provided including hospitals and mental health agencies. Services need be affordable. In addition to increased language capacity, there was also interest in a public education campaign to promote better understanding of how and where to get help and what are mental health services and how to identify triggers. Providing education on western medicine practices and eastern medicine practices would be helpful.

What could have helped after the crisis?

Aftercare and transitional services was a dominant theme in this segment. Having a support person to stay with the consumer throughout services, family and peer advocates all working together, follow-up therapy, phone calls, visits, assessments and linkages to resources were identified.

A second focus was increasing supports within the community, utilizing natural helpers like clergy, peer respite, peer drop-in and counseling services, community settings open to socialization opportunities and wellness activities could have helped.

Strategy A : Full Spectrum Respite Program

Description:

- Full spectrum respite services that are easy to access and are in various locations in the community
- Respite would be a first point of contact and would be brief/time-limited, up to 24-48 hours
- Services would include treatment practices that can reduce the stress and pressures that come from a crisis experience
- Respite services empower individuals to feel supported and able to maintain without needing hospitalization
- Services would build on the existing network of mental health services, expanding a service continuum and enhancing options for consumers and family members.
- There is the potential to leverage existing facilities to implement this strategy.

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Children/Youth:** There is a need to provide options for adults experiencing a crisis and who have dependent children in the home. There is a need to have separate services for youth/TAY that include separate living arrangements, provide education on different issues, hire staff that understand youth issues.
- **Structure:** Some participants favor a drop in over a residential program and favor flexibility in the kinds of services available. They see it open 24 hours but not for overnight stays.
- **Services:** Recommendations to have ways to deal with stress release such as having punching bags available, dance class or music. Have a specific focus on individuals going off of substances. Teach mindfulness, coping skills. Residents should be able to come and go as they want. The program should be longer than 48 hours. An aftercare service should be included. There should be opportunities to go outside.
- **Outreach:** Promote services in ways that can be heard and understood by different cultural communities. The way services are presented need to appeal to and make sense to different cultural groups. The idea of linkages continues to be supported

Strategy B: 24-Hour Crisis and Transitional Care Coordination Center with a Wellness and Recovery focus

Description:

- Coordination of care that is centralized
- Services include
  - crisis and triage services
  - immediate access to support
  - trained peer "navigators" to help navigate the system and link to other needed services
  - transportation
  - aftercare or transitional care to assist with continued progress
- Wellness and Recovery and Medical models are combined and practiced
- Psychiatrists and physicians will be trained in Wellness and Recovery concepts
- Service providers would also link to each other or develop a network, therefore creating a system consumers could easily navigate
- The following data/information will be collected: consumer information at intake and discharge, cause of crisis, and service satisfaction

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Volunteer Capacity:** Use consumer and community members as volunteers to leverage for sustainability and provide aftercare, one on one support or support groups. Use trainees and interns and volunteers to provide alternative services
- **Outreach:** Offer a 24/7 warm line for counseling or referrals to other services. Create an interactive website that maps and links services. Have computers on site for networking. Recruit local businesses for sponsorship of alternative services
- **Services**: Have bi-lingual staff available on site. Consider using Peer Sponsors, similar to the AA model. Offer alternative services such as meditation, workout room, yoga acupuncture, healing, music, and massage.

Questions to consider: Will there be bi-lingual staff available 24/7? Transportation needs to be clearly defined (e.g. taxi services, door-to-door transportation, vans, mileage reimbursement). Specific services need to be defined. Will mobile services be offered? What is the eligibility criteria? Does this model include residential? The scope of this strategy seem very broad and ambitious and the workgroup might consider limiting the scope.

Strategy C: Integrated Wellness and Recovery Behavioral Health Workforce ATTACHMENT H

Description:

- Peers, family members, interns, and licensed staff without lived experience mutually learn, and share experiences and resources related to wellness and recovery and clinical practice with each other
- Leverage and collaborate with existing partners such as the Department of Rehabilitation, Department of Labor, UC Davis, CSUS, community colleges and consumer advocates and networks

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- Develop a peer certificate program where the purpose is consumer empowerment (rather than building a workforce) or
- Develop a "Peer Academy" where peers and professionals learn about the recovery process as equals
- **Principles**: Include education classes for families. Define a skill set that is tiered to a set of competencies. Have clear expectations.
- **Specifics**: Teach relationship skills, Emotional Freedom Techniques, self care, exercise, nutrition, yoga, meditation, dragon breathing, and wellness. Celebrate milestones with wellness activities at things like graduation, weddings deaths, etc.
- **Sustainability**: Use volunteers, leverage existing resources

Strategy D : Non Traditional Community Resources for Outreach and Collaboration

Description:

- Develop a project that can address crisis in culturally and linguistically specific ways because:
  - Some languages or cultures have unique beliefs and understanding about mental health
  - In some cultures there is no specific word to use to translate the concept of mental health
  - Without a culturally specific crisis model, there is a tendency to use a "one-size fits all" approach
  - Not everyone understands what 911 means or what to expect when 911 is called for an emergency or crisis
- Examples
  - Develop a crisis response tailored to assist African Americans
  - Develop a Peer Run program serving a specific cultural community
- To meet the needs of cultural and linguistic communities, utilize non traditional services such as
  - Faith-based community
  - Colleges and universities where student peer support services could be provided

Intended Outcomes:

- A more diverse and culturally competent provider network that can provide increased access to underserved
- Culturally tailored services such as housing, respite care, community support groups that can reduce isolation
- A more supportive community able to value differences and able to respond appropriately to crisis

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Program Location:** Cultural and ethnic community members recommended that they would feel more comfortable receiving services at Community Centers. Because of transportation issues, program services should also be provided at multiple sites.
- **Program Services:** Incorporate nature, animal therapy, prevention, and early intervention into services. Parent education and support services are available for parents. Services are provided at the community members homes. Program provides language support for 911 dispatchers and law enforcement. Crisis and Warm Line services are available for specific cultural and ethnic communities. One-Stop services, social activities, after hour services and information line with language support are available for our cultural and ethnic communities.
- **Education:** Education about mental health, mental wellness, services and resources is provided to families. Youth will train youth on mental wellness and cultural awareness in schools.
- **Program Staff:** Staff and community providers will be trained on how to use interpreters.

- **Training for Other Providers/Partners and Community Leaders:** Training about mental health, services and resources, cultural sensitivity, use of interpreters is available to other providers, partners, community leaders.
- **Outreach and Promotion:** Outreach activities are provided at community members homes. Employ different types of media to outreach, educate, and promote services (e.g., Ted.com, YouTube, Twitter, Facebook, Tumblr, Downelink, and other social media/networking). Promote services through local churches and ethnic community radio, papers, TV stations. Target outreach to people that lack transportation.

Questions to consider: Will this program include residential treatment? If so, long or short term? Would there be repercussions with CPS? What about services for undocumented individuals? Strategy D concepts should be incorporated into other strategies.

Strategy E : Voluntary Full Spectrum- 100% Peer/Community/Family Run Programs in Homelike Settings

Description:

- A program that can address crisis primarily in a neighborhood homelike setting
- Array of crisis services would be voluntary, peer run and designed to meet a variety of needs
- Access to services would be 24/7 and available through phone consultation, walk-in or some kind of mobile service
- Creating a feeling of safety and sanctuary would be a guiding principle
- Child and family support and transportation to and from this program would be provided
- Services would not be restricted by age; rather they would include the whole family

Goal:

- More people will seek services prior to a crisis escalating and requiring hospitalization. The ability to work through a crisis in an environment where there is a support system in place and the opportunity to stabilize in the least restrictive setting could allow an individual to progress at their own pace. Overcoming a crisis can sometimes be a growth opportunity and contribute to an increased sense of empowerment and self esteem.

Intended Outcomes:

- Increased awareness of peer support as a modality for care.
- Decrease in expensive hospitalization
- Enhance the existing continuum of services

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Program Location**: Multiple locations with home-like settings, sited in neighborhoods, sited where community members live.
- **Program Structure and Services**: Program is culturally specific (to include the provision of traditional healing practices), language specific, age specific, gender specific. Program incorporates faith-based community in the provision of services. Program services are offered to veterans and those with other disabilities. Prevention services, linkage to other resources and services are included. Information line with language support is another service of this program. Education about mental health, resources and services and Western approaches to mental health treatment. Bi-lingual staff or interpreters are available to assist with navigating the system.
- **Program Staff and Staff Training**: Staffing is integrated and represents those with lived experience, have other types of lived experience (e.g., homelessness), reflect different age ranges, the cultural diversity of the county, are identified as

LGBTQQIA, bi-lingual, professional. Train staff on "Shame Resilience Theory" (Brené Brown), cultural sensitivity, and traditional healing practices.

- **Outreach and Promotion:** Implement outreach activities to promote services to unserved and underserved communities.

ATTACHMENT I

Sacramento County MHSA Innovation Workgroup Meeting #3
Meeting Summary
March 30, 2011, 9:00 am – 5:00 pm
Voter Registration Office, 7000 65th Street, Sacramento, CA 95823

Goals

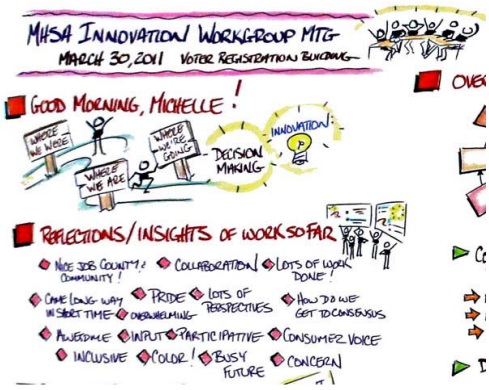
- Review the Innovation planning process, including roles, responsibilities and next steps.
- Introduce the draft Innovation Recommendation, which incorporates the draft strategies and community input.
- Identify priorities, clarify terms and discuss pro/cons of options in order to refine the draft Innovation Recommendation.
- Strengthen the foundation of trust among Innovation Workgroup team members.

I. WELCOME & INTRODUCTIONS

Welcome and opening remarks were made by Michelle Callejas, MHSA Program Manager. Michelle thanked Innovation Workgroup members for their hard work up to this point in time and asked them to have open minds and hearts as they develop a plan that best serves our community.

Deb Marois, Innovation Planning facilitator, re-introduced Greg Gollaher, Graphic Illustrator, and announced that Carol Wright, Innovation Planning co-facilitator was not able to attend this meeting. Deb reviewed the agenda, goals for the meetings, ground rules. The meeting materials were also reviewed including the February 10, 2011 Meeting Summary that brought in Susanna Gee's suggested additions: that she asked Workgroup members to consider Los Angeles and Trinity Counties Innovation Plans and the Title 9 definition of crisis residential treatment services.

Workgroup members re-introduced themselves and were invited to peruse walls of the room covered with Innovation Workgroup Planning meeting graphic recordings to date. Workgroup members were asked to reflect on their work and to share one thing that stood out for them in the process thus far.



Sacramento County MHSA Innovation Workgroup Meeting #3
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Voter Registration Office, 7000 65th Street, Sacramento, CA 95823

II. PLANNING PROCESS REFRESHER

Deb revisited the Innovation Planning process. The Planning process is now just over mid-way. At the last meeting, the Workgroup members developed draft strategies that were not fully "cooked" to allow for community input. Since then, the Community's input has been integrated into the draft recommendation. Deb reminded the Workgroup to focus on interests rather than positions. Multiple stakeholder groups have and will contribute input in the Innovation Plan; therefore, the greater level of consensus equals greater level of potential for implementation. (Refer to "Contributors to the Plan" and "Refresher Power Point" Handouts)

III. OVERVIEW OF DRAFT INNOVATION RECOMMENDATION

MHSA Team presented an overview of steps that were taken to build the draft Innovation recommendation:

Michelle Callejas, MHSA Program Manager, acknowledged the hard work of the Workgroup members and that their thinking and work was the primary basis for the draft recommendation. The Workgroup started with the Kick-off and Orientation meetings which consisted of learning about the principles of the Innovation Component, presentation of past planning processes and data related to crisis in Sacramento County, tours, development of crisis definition, discussing learning goals. The Workgroup took into consideration all of the information presented and their generated ideas and concepts and developed many strategies. The MHSA Team captured, organized and synthesized the Workgroups ideas and sent five (5) strategies back to the Workgroup members for review and feedback. The Team incorporated Workgroup members' feedback, made adjustments, and prepared the draft strategies for community input.

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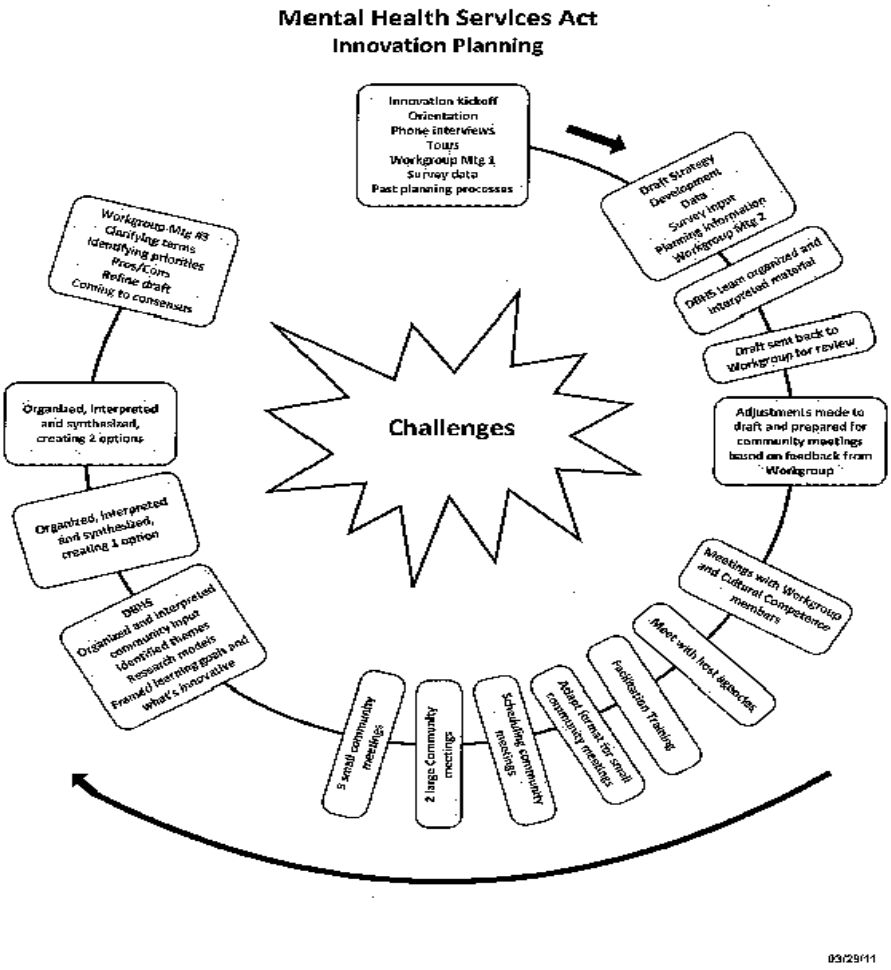

3

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Julie Leung, MHSA Program Coordinator, reviewed the Community Input process. Two (2) Community Input meetings were already scheduled for the community at large. However, Workgroup members together with DBHS Cultural Competency Committee members were committed to reaching out to our cultural and ethnic communities for their input. Members of both groups met to develop a plan for outreach which resulted in brainstorming recruitment strategies and identifying host agencies for small group community input.

Those host agencies met to further develop small group input meetings targeting cultural and ethnic communities. These agencies hosted (9) small group community input meetings. Both large and small group community meetings resulted in a total of 169 people in attendance and providing input into the Workgroup's draft strategies.

There were common and divergent themes that emerged from both the large and small community input meetings:

Kathryn Skrabo, MHSA Program Planner, discussed the challenges of organizing, integrating, and synthesizing all information, ideas, and input from the Innovation Planning process to date. There were challenges in determining the learning goal and what was innovative. Kathryn walked the Workgroup through the different iterations of the draft strategies, the elements of the five (5) draft strategies that were included or excluded, decision points, resource limitations and leveraging opportunities with existing assets. She also reviewed existing MHSA funded programs to illustrate that some of the Workgroups' ideas were already in place or ready to be implemented. Additionally these existing MHSA funded programs present opportunities for linkage and leveraging.

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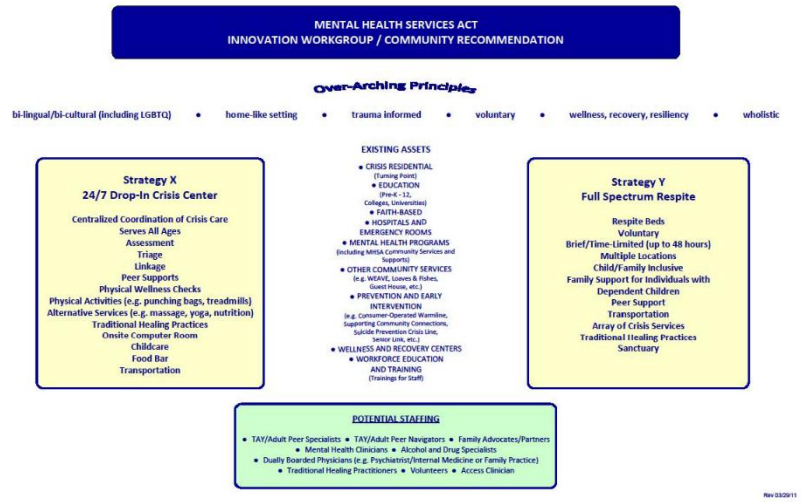

Michelle Callejas concluded the review by describing the strengths and questions/concerns about the current draft recommendation. Strengths of this recommendation include: 1) reflects community input; 2) included alternatives not seen before in Sacramento e.g. yoga blending of peer and medical models; 3) potential for specific elements to be innovative. Remaining questions and concerns include: 1) what is the learning goal; 2) what is innovative; 3) multiple locations; 4) siting and zoning concerns.

The Workgroup members and members of the public also contributed clarifying questions:

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Rules and Regulations related to crisis residential siting:
John Buck, Turning Point Community Programs, Mike Lazar, Transitional Living Community Services, and Lynn Place, Human Resources Consultant, informed Workgroup members about rules and regulations related to crisis residential siting:

IV. RECOMMENDATION REVIEW AND REFINEMENT

Deb Marois directed Workgroup members to work in trios to discuss and answer the following questions: What concepts/elements are most important to include in the final Innovation recommendation? Could any of the elements be combined to create a more Innovative recommendation? If so, how?

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Workgroup members selected the following concepts as important to include in the final recommendation:

Important Concepts	Workgroup Dots	Public Dots
Peer Support ○ On-going training ○ Navigating the system ○ Individuals with lived experience ○ Youth, parents/caregivers	15	6
Family support ○ For both parents and child ○ Broad family support/helping the whole family unit ○ Can include members of family/loved ones ○ Training ○ Navigating ○ Not mandatory	14	4
Complementary and alternative methods ○ culturally, traditional healing practices ○ culturally specific	12	5
Centralized coordinated care ○ place where people know they can call ○ serves as a starting place	12	1
Transportation	10	6
Multiple locations	10	2
Assessment, triage and linkages ○ Benefits coordination	9	3
In neighborhoods	8	5
Staff with lived experience	6	2
Respite space	5	2
In-Home respite ○ families can live there	4	1
Close connection with all existing services ○ Care coordination if requested ○ Active communication with other service providers	1	7
Respite that is not structured unless requested ○ Structure is available but not required	0	2
Serves all ages	0	1
Self-referral/self-directed ○Self-determination, autonomy	0	1

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Deb then had Workgroup members and members of the audience dot-vote for three of their most important concepts/elements (see table above). After everyone dot-voted, the following concepts/elements "made the cut":

The Workgroup members were asked again to work in trios to discuss how these prioritized elements could be implemented in an Innovative way. Deb reminded the Workgroup of the following approaches:

- New, adapt, or adopt models or practices from other fields
- Unique collaborations: funding mechanisms, specific populations
- Combining elements in new ways or at new locations
- Shared learning opportunities
- Address multiple issues

The Workgroup members and members of the public reported out with the following Innovative ideas:

- Roving Supervision
- Psychiatric interns and Peers trained together
- Use of technology: access to computers to reduce isolation, improve access, connections, and provide tele-support
- Coordination to improve access to alternative/complementary services
- Ways to build capacity for competitive bidding for community based organizations (e.g. scholarship fund, grant writers)
- Wholistic Center that addresses multiple issues
- Address transport issues to prevent relapse because they can't get to appointments; a "Ride for Help"; find ways to get people where they need to go
- Using culturally trained drivers to provide transportation
- How can volunteers be used innovatively; volunteers can provide transportation
- Native American Health Center model – smaller and in African American community

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- Getting services to person as quickly as possible, more authority at first contact
- Engage culturally specific groups in small learning circles, innovations in prevention
- Be a model for Peers getting reimbursement from Medi-Cal; Peer services are Medi-Cal eligible; create more opportunities for Peer reimbursements; different states have different Medi-Cal rules
- Sustained funding from emergency rooms to help fund (incentive for hospital) – Outcome: reduce over crowding (national problem)
- Measure results and show improvements
- Employ those with "lived experience"; peer staff at all levels; reimburse Peer services; use people with "lived experience" and training, etc (include language training)
- End "hand offs", maintain community and consistency throughout continuum; peer and cultural support
- Language training for competency

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VI. NEXT STEPS

Workgroup members were reminded of the following:

- Innovation Workgroup Meeting #4: April 19, 2011, 12pm – 5pm, 7001A East Parkway, Conference Room 1, Sacramento.
- Provide updates to Alternate members before Workgroup Meeting #4.
- Homework: Think about models, methods and/or practices that can be used to implement the concepts/elements you dot-voted on in an Innovative way. Is there a model, method or practice that is new or that can be adopted or adopted that incorporates these ideas/elements? Share your ideas and concepts by sending them to InnovationWorkgroup@SacCounty.net by noon, April 6, 2011.
- Send any correspondence to InnovationWorkgroup@SacCounty.net

Sacramento County MHSA Innovation Workgroup Meeting #4
Meeting Summary
April 19, 2011, 12:00 pm – 5:00 pm
7001A East Parkway, Conference Room 1, Sacramento, CA 95823

Goals

- Review the draft Innovation recommendation and provide final comments before it is brought to the MHSA Steering Committee for review.
- Reflect on lessons learned and provide feedback on the Innovation planning process.
- Discuss next steps in finalizing the Innovation plan and the role of Workgroup members as community ambassadors.
- Strengthen the foundation of trust among Innovation Workgroup team members.
- Celebrate the conclusion of the Innovation planning process and acknowledge contributions of team members.

I. WELCOME & INTRODUCTIONS

Welcome and opening remarks were made by Michelle Callejas, MHSA Program Manager. Michelle reminded the Workgroup members that this is our last meeting and thanked members and alternates for their contribution to this process. Today's the focus will be to refine the Innovation recommendation, take it forward to the MHSA Steering Committee, and celebrate.

Deb Marois, Innovation Planning Facilitator, reviewed the agenda, goals for the meeting, ground rules, and meeting materials. Deb facilitated a warm-up reflection exercise. She asked Workgroups members to think about that they've as a result of participating in the Innovation planning process. Workgroup members were asked to write down their responses and to also share one thought from their reflection:

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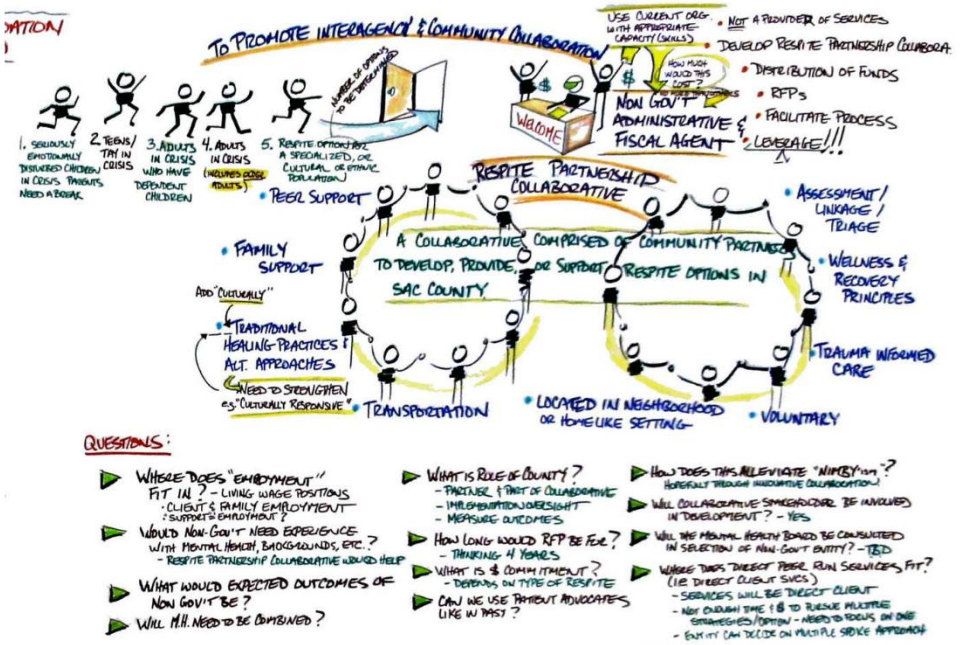
7001A East Parkway, Conference Room 1, Sacramento, CA 95823

II. OVERVIEW OF RECOMMENDATION

Michelle Callejas reviewed the draft recommendation with the WG members. Based on the ideas that came out of this planning process and prior planning processes and feedback from the community related to the County's limitations in the implementation processes, the MHSA Team developed the Respite Partnership Collaborative. This Respite Partnership Collaborative's composition would be community partners that would develop, provide or support respite options in Sacramento County. They would be responsible for tracking and coordinating respite options, building linkages to other community resources and MHSA programs, host community stakeholder meetings, evaluate respite programs, ensuring that all programs incorporate guiding principles, maintain networking technology. The Respite Partnership Collaborative could be established, organized and facilitated by a non-county administrative which would provide administrative and fiscal support for respite projects developed by the Collaborative. Goal is to build new partnerships that can lead to better coordination of care and new practices, maximize existing resources, establish a continuum of respite services that will reduce mental health crisis. (Refer to Draft Innovation Plan)



Using the levels of agreement, Deb Marois asked the Workgroup members how much did each member agreed to the following question: Should the draft Innovation plan move forward to the MHSA Steering Committee? Those that were in "strong support" expressed the following:

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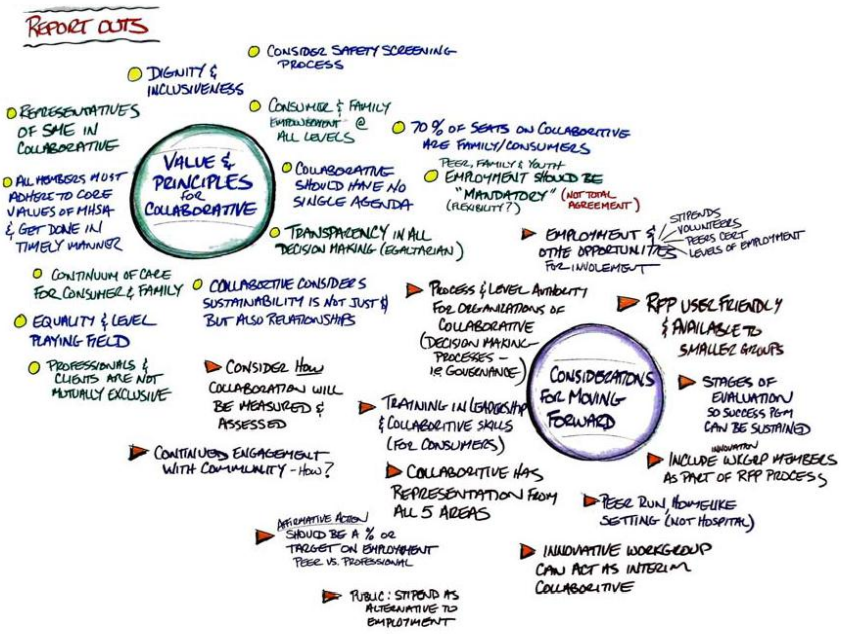
1) the draft plan is a new and innovative way about providing respite services; 2) they were excited about putting respite in the project; 3) acknowledged that the plan is inclusive of parents. Members who were "supportive with minor concerns" wanted concepts to be further clarified: 1) needs more strength based language related to peer and family member support/employment; 2) concerned about selecting the administrative entity; 3) unclear about the administrative entity; 4) administrative entity's role needs to be true to the intent of the draft recommendation; 5) relationship between the Respite Partnership Collaborative and administrative entity needs to be more clear; 6) the Collaborative's process for selecting services needs to clarified. Those that had "strong concerns" noted that they did not have enough information to support the draft recommendation. Members that "could not support" the recommendation were concerned that employment of consumers and family members was excluded from the recommendation.

Following the straw pole exercise, Workgroup members were directed to work in trios to discuss and answer the following questions: What values or principles are important to consider in forming this collaborative? What do we need to consider as we move forward? Workgroup members reported out the following:



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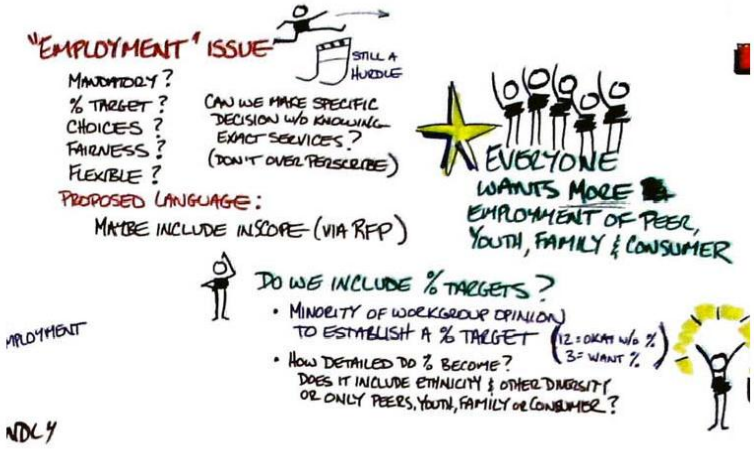
Some Workgroup members voiced their concerns consumer and family member representation on the Respite Partnership Collaborative and suggested that the draft recommendation identify a specific percentage of consumer and family member Collaborative representation. A majority of the Workgroup members voted for flexibility within the draft recommendation rather than being tied to specific percentages and details.



Deb Marois called for a final vote, using levels of agreement. A very small number of Workgroup members had major concerns with the draft recommendation but were okay about sending the document forward.

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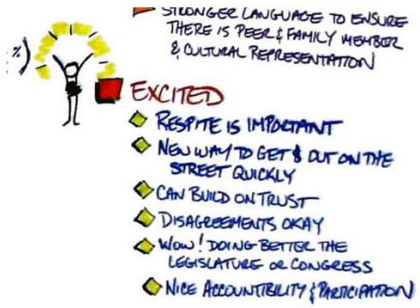
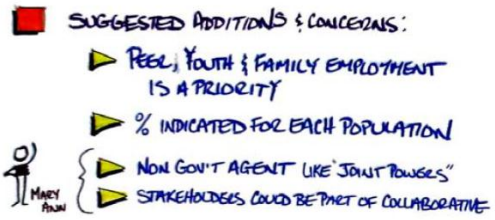


A majority of all Workgroup members were in strong support of the draft recommendation and expressed their excitement about the plan.

The Workgroup members made some suggestions for additions:



III. PUBLIC COMMENT

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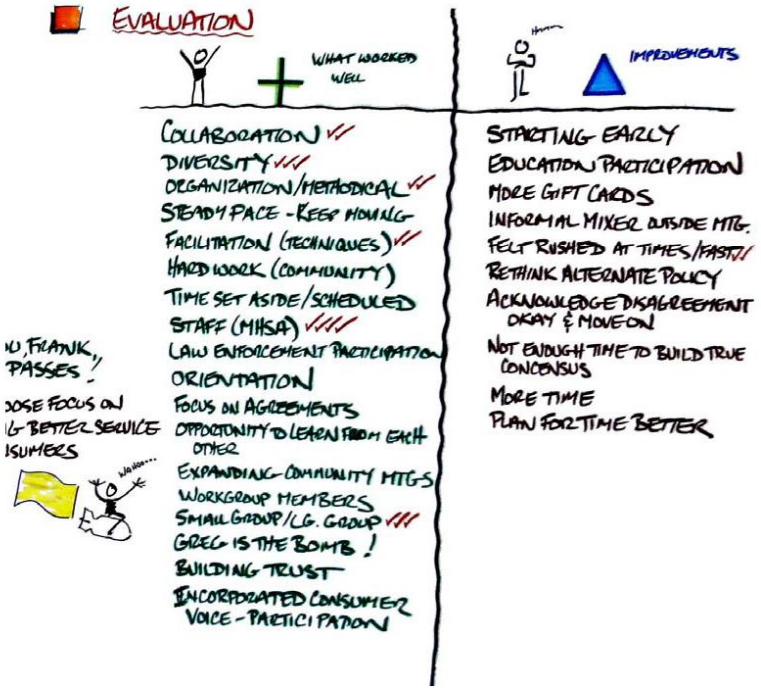
IV. INNOVATION PLANNING PROCESS EVALUATION

Deb Marois asked all Workgroup participants and the public to complete the Innovation Planning Process Evaluation. In a large group discussion, she asked all participants: What worked well with this planning process? What suggestions do you have to improve future planning processes?



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VI. CELEBRATION AND CLOSING

MHSA Team acknowledged the contribution of the Workgroup and presented each Workgroup member with a certification of appreciation and an Innovation "light bulb". The team also acknowledged the public for their contributions.

VII. NEXT STEPS

- MHSA Team will refine the Draft Recommendation to include important concepts generated by the Workgroup members from Meeting #4
- Draft Recommendation will be presented to the MHSA Steering Committee on May 5, 2011, 6:30 – 8:30pm, 7001A East Parkway, Conference Room 1, Sacramento. All Workgroup members and alternates are encouraged to come to this meeting.
- Send any correspondence to InnovationWorkgroup@SacCounty.net

Appendix B. About AIR and the Evaluation Team

About the American Institutes for Research (AIR)

AIR (www.AIR.org) is a not-for-profit corporation engaged in independent research, development, evaluation, and analysis in the behavioral and social sciences. Since our founding in 1946, we have worked with government agencies as well as public and private organizations including state and local government agencies, state and local education agencies, foundations, corporations, courts, and schools, both in the United States and abroad. As a result of placing a high value on responsiveness, flexibility, product quality, and timeliness, AIR has earned a national and international reputation for efficiently and effectively conducting work that consistently meets the needs of our clients. We are organized around six program areas:

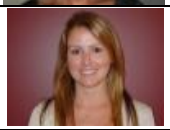
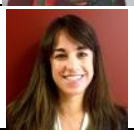
- Analysis of Longitudinal Data in Education Research (ALDER)
- Assessment
- Education
- Health and Social Development
- International Development
- Workforce

The Health and Social Development program addresses overall health and well-being—physical, mental, social, emotional—across the lifecycle where people live, learn, work and play. Our work spans and integrates promotion, prevention, intervention, care delivery, and recovery. We specialize in research and evaluation, training and technical assistance, and communication and social marketing campaigns to improve access, delivery, consumer experience, cost effectiveness, and outcomes for children, youth, adults, seniors, and families.

We work in and across systems of health care delivery, public health, and behavioral health as well as human service systems of education, juvenile justice, child welfare, youth development, and homelessness and housing. We actively engage patients, consumers, young people, families, and communities in shaping the policies and services that affect them. Our methods are culturally and linguistically competent.

Our staff of more than 200 experienced professionals have advanced degrees in public health; health policy, administration, and economics; behavioral and mental health; nursing and medicine; social science, education, and social work; law and criminology; youth development and aging; and communications. We work to improve how health care and social services are organized and delivered in urban, suburban, rural, and tribal settings across the U.S. and in several countries.

Meet the Evaluation Team

Project Directors	
 **Grace Wang, PhD** **gwang@air.org** **650-843-8191 (w)**	**Dierdre Gilmore, MS** **dgilmore@air.org** **650-843-8139**
Project Manager	
 **Roshani Fernando** **rfernando@air.org** **(650) 843-8145**	
Team Members	
 **Brandy Farrar, PhD** **bfarrar@air.org** **202-403-5416**	
 **Laurel Koester, MPH** **lkoester@air.org** **212-419-0415**	
 **Elena Lumby, MPH** **elumby@air.org** **(202) 403-5957**	
 **Katie Manson, MPH** **kmanson@air.org** **650-843-8116**	

Appendix C. RPC Member Survey Results

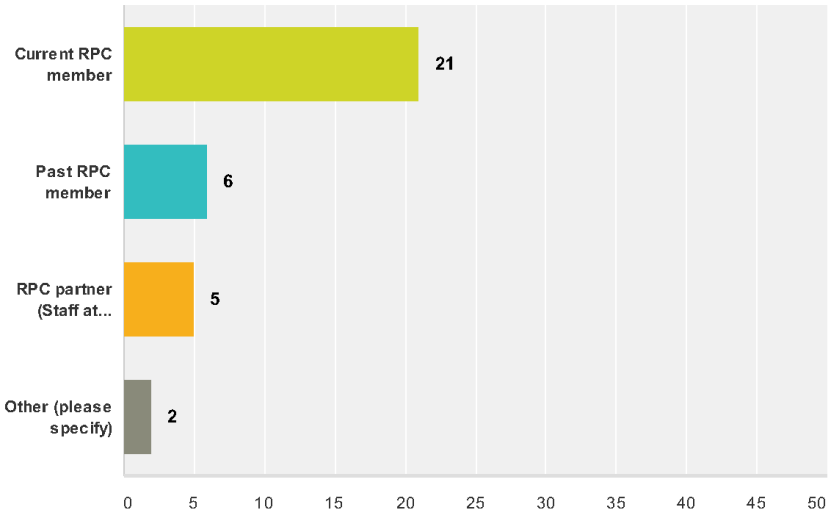
RPC Member Survey Results

Note: Result findings that could easily identify a participant were redacted from the results.

RPC member survey

Q1 What is your role in the RPC? Select more than one response, if appropriate.

Answered: 31 Skipped: 0

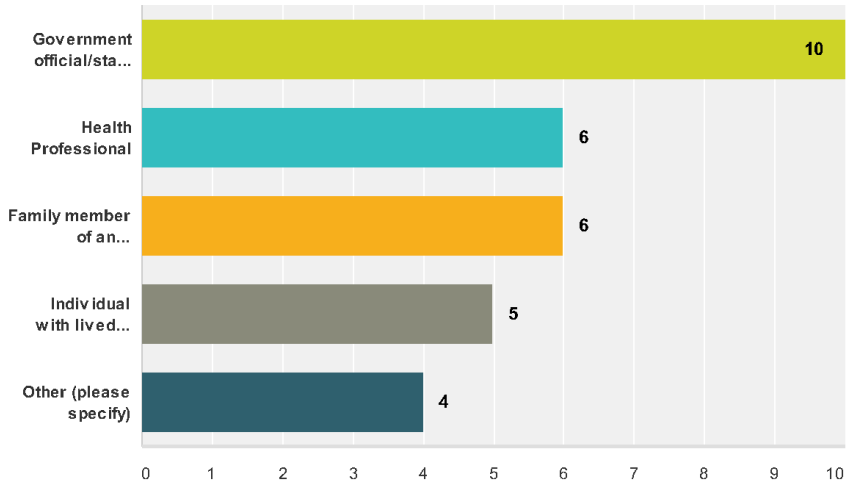


Answer Choices	Responses
Current RPC member	67.74% 21
Past RPC member	19.35% 6
RPC partner (Staff at Sierra Health Foundation: Center for Health Program Management or Sacramento County Division of Behavioral Health Services)	16.13% 5
Other (please specify)	6.45% 2
Total Respondents: 31	

#	Other (please specify)	Date
1	Facilitator	11/26/2013 3:45 PM
2	MHSA Steering Committee and Mental Health Bd. Member	11/21/2013 12:00 AM

Q2 Please select the role that fits you best. Select only one.

Answered: 31 Skipped: 0

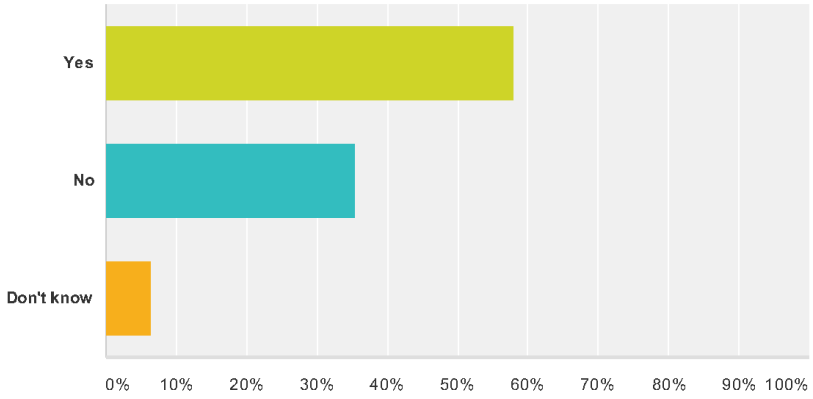


Answer Choices	Responses	
Government official/staff or staff from a non-profit	32.26%	10
Health Professional	19.35%	6
Family member of an individual with lived mental health experience	19.35%	6
Individual with lived mental health experience	16.13%	5
Other (please specify)	12.90%	4
Total		31

#	Other (please specify)	Date
1	I am "best" described by 1-4 above	2/19/2014 2:27 PM
2	Organizational and community development consultant	11/26/2013 3:45 PM
3	Representing ethnic minorities and faith based organization	11/19/2013 6:02 PM
4	Cultural/Ethnic group	11/13/2013 4:46 PM

Q3 In your opinion, does the RPC have sufficient representation of stakeholders from Sacramento County to accomplish the objectives of the RPC?

Answered: 31 Skipped: 0



Answer Choices	Responses	
Yes	58.06%	18
No	35.48%	11
Don't know	6.45%	2
Total		31

Q4 Which type of stakeholders are NOT well represented on the RPC? Select all that apply.

Answered: 11 Skipped: 20

Answer Choices	Responses
Hospital Emergency Department	63.64% 7
Hospital Council/Community Mental Health Partnership	54.55% 6
Law Enforcement	54.55% 6
Transition Age Youth	54.55% 6
Nontraditional Mental Health Provider inclusive of peer-run services, spiritual healing and alternative medicine	45.45% 5
Alcohol and Other Drug Service Provider	27.27% 3
Education	27.27% 3
Faith-Based Organizations	27.27% 3
Health Sector	27.27% 3
Juvenile Justice	27.27% 3
Veterans	27.27% 3
Other (please specify)	27.27% 3
Child Welfare and/or Foster Care	18.18% 2
Foster Youth	18.18% 2
Homeless, Lived Experience	18.18% 2
Individual with Lived Mental Health Experience	18.18% 2
Persons with Disability	18.18% 2
Cultural or Ethnic Community (please specify under other)	9.09% 1
Disability Organization	9.09% 1
Homeless Service Organization	9.09% 1
Mental Health Service Provider Association	9.09% 1
Organization Serving Children and Youth	9.09% 1
Patient Rights Advocate	9.09% 1
Total Respondents: 11	

#	Other (please specify)	Date
1	Elected officials, policy makers, leaders within the mental health providers association	11/26/2013 3:49 PM
2	Deaf Community	11/22/2013 8:08 AM
3	Public health	11/19/2013 7:46 AM

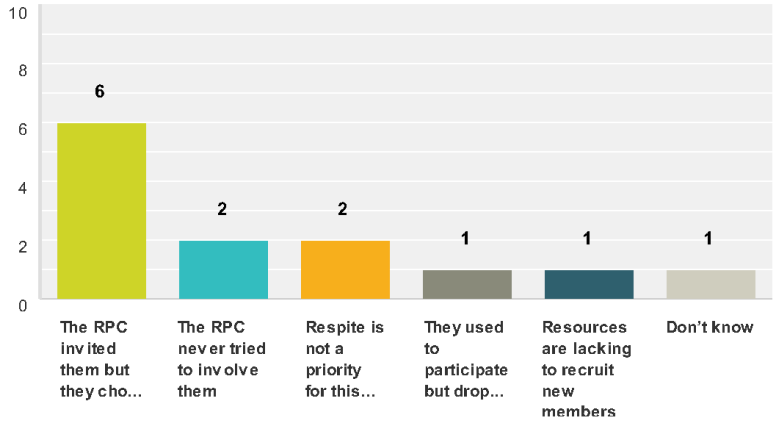
Q5 If you have selected multiple stakeholders as being not well represented, please select the SINGLE stakeholder you think is most important to add to the RPC at this time. Write the stakeholder in this box:

Answered: 9 Skipped: 22

#	Responses	Date
1	Peer crisis respite provider	12/30/2013 2:16 PM
2	Hospital Council	11/26/2013 3:49 PM
3	Health Sector	11/26/2013 7:39 AM
4	Deaf Community	11/22/2013 8:08 AM
5	Mental Health Service Provider	11/21/2013 11:08 AM
6	LAW ENFORCEMENT	11/19/2013 2:12 PM
7	Hospital Emergency Dept	11/19/2013 7:46 AM
8	Law Enforcement	11/17/2013 10:19 AM
9	Disability ... REGIONAL CENTER	11/15/2013 11:36 PM

Q6 Why do you think the stakeholder identified as most important to add to the RPC is not well represented at this time? (SELECT ALL THAT APPLY):

Answered: 9 Skipped: 22

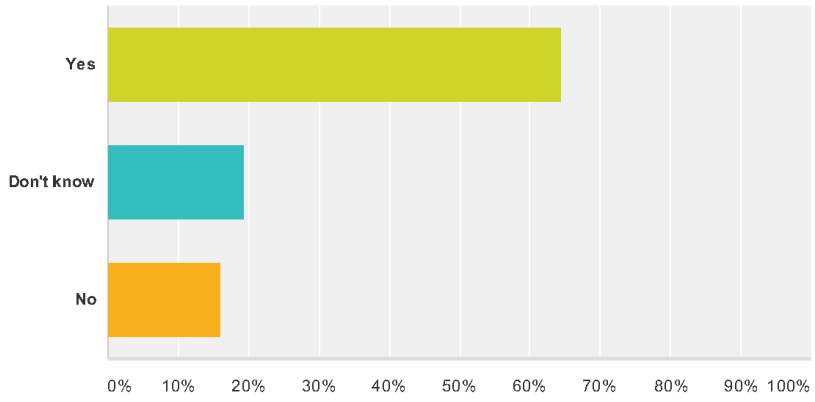


Answer Choices	Responses	
The RPC invited them but they chose not to participate	66.67%	6
The RPC never tried to involve them	22.22%	2
Respite is not a priority for this group	22.22%	2
They used to participate but dropped out	11.11%	1
Resources are lacking to recruit new members	11.11%	1
Don't know	11.11%	1
Total Respondents: 9		

#	Other (please specify)	Date
1	Experience from a provider who really knows how these services run is important.	12/30/2013 2:16 PM
[redacted]	[redacted]	[redacted]
3	I suspect there are other political reasons at play	11/26/2013 3:49 PM
4	Used to participate but no accomodation was made to enable represenation to continue.	11/22/2013 1:10 PM
5	The time commitment is challenging and providers are concerned they could not apply for respite grants if seated on Collaborative	11/21/2013 11:08 AM

Q7 In your opinion, do new members receive adequate orientation to be effective members of the RPC?

Answered: 31 Skipped: 0



Answer Choices	Responses	
Yes	64.52%	20
Don't know	19.35%	6
No	16.13%	5
Total		31

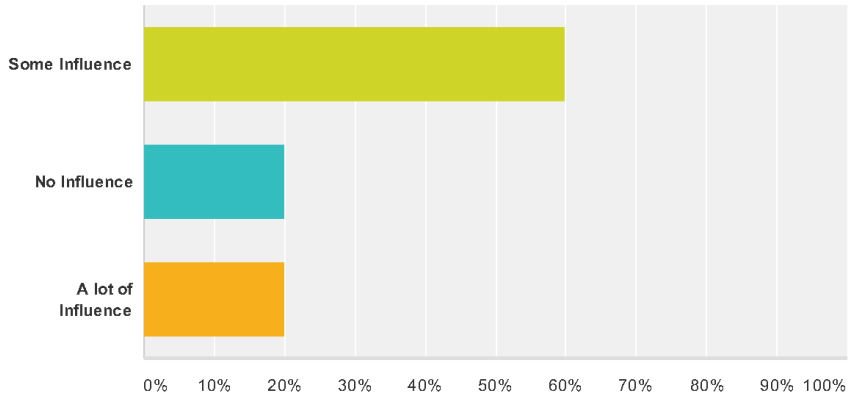
Q8 Please select how much influence these groups have in deciding on the actions and policies for the RPC.

Answered: 30 Skipped: 1

	No Influence	Some Influence	A lot of Influence	Total	Average Rating
Sierra Health Foundation: Center for Health Program Management	6.67% 2	16.67% 5	76.67% 23	30	1.00
Sacramento County Division of Behavioral Health Services (DBHS)	3.33% 1	36.67% 11	60.00% 18	30	1.00
RPC facilitator	16.67% 5	36.67% 11	46.67% 14	30	1.00
RPC members	0.00% 0	51.72% 15	48.28% 14	29	1.00
Grantmaking and Evaluation Committee	0.00% 0	53.57% 15	46.43% 13	28	1.00
Governance and Membership Committee	3.45% 1	58.62% 17	37.93% 11	29	1.00
Sustainability, Public Policy, and Collaboration Commitee	11.11% 3	74.07% 20	14.81% 4	27	1.00
Communication Committee	37.04% 10	55.56% 15	7.41% 2	27	1.00

Q9 Please select how much influence you personally have in making RPC decisions.

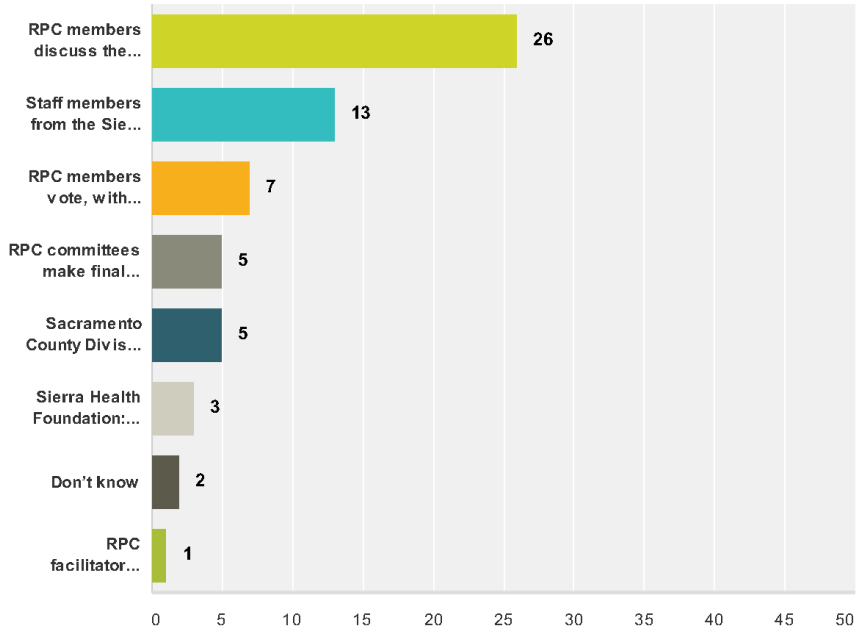
Answered: 30 Skipped: 1



Answer Choices	Responses	
Some Influence	60.00%	18
No Influence	20.00%	6
A lot of Influence	20.00%	6
Total		30

Q10 Which of the following best describes how decisions are usually made regarding RPC priorities, policies and actions? (SELECT ALL THAT APPLY):

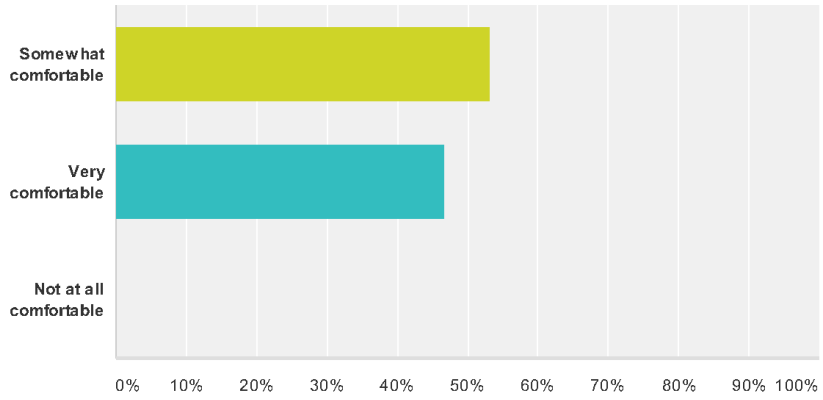
Answered: 31 Skipped: 0



#	Other (please specify)	Date
[redacted]	[redacted]	[redacted]
2	The agenda and direction are set before the meetings. The RPC makes some decisions but usually filling in the details of the pre-set agenda in most cases. Things have been changing with the rising up of some strong committees so there might be more of a say for RPC members now.	11/22/2013 8:53 AM
3	Some guidance is often sought by RPC Mbrship of SHF and DBHS but it's mostly by consensus by the RPCmbrship under guidance by the facilitator -- excelent	11/21/2013 12:06 AM
4	I feel it is very collabaortive process with no one entity making final decisions	11/13/2013 4:38 PM

Q11 How comfortable are you overall with the RPC decision-making process?

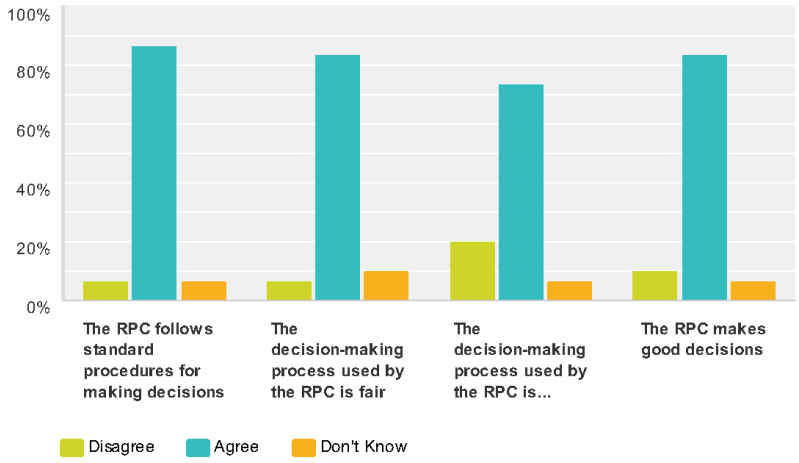
Answered: 30 Skipped: 1



Answer Choices	Responses	
Somewhat comfortable	53.33%	16
Very comfortable	46.67%	14
Not at all comfortable	0.00%	0
Total		30

Q12 Please select how much you agree or disagree with the following statements.

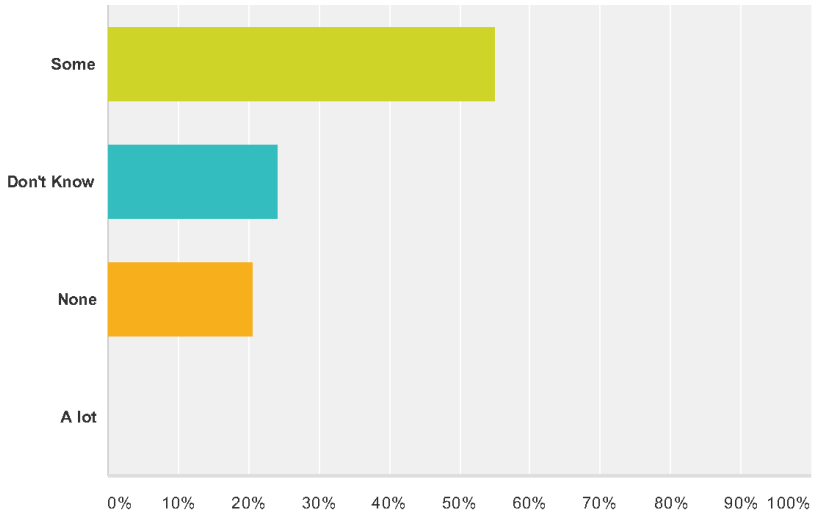
Answered: 30 Skipped: 1



	Disagree	Agree	Don't Know	Total	Average Rating
The RPC follows standard procedures for making decisions	**6.67%** 2	**86.67%** 26	**6.67%** 2	30	1.00
The decision-making process used by the RPC is fair	**6.67%** 2	**83.33%** 25	**10.00%** 3	30	1.00
The decision-making process used by the RPC is timely	**20.00%** 6	**73.33%** 22	**6.67%** 2	30	1.00
The RPC makes good decisions	**10.00%** 3	**83.33%** 25	**6.67%** 2	30	1.00

Q13 How much conflict is there in the RPC?

Answered: 29 Skipped: 2



Answer Choices	Responses	
Some	55.17%	16
Don't Know	24.14%	7
None	20.69%	6
A lot	0.00%	0
Total		29

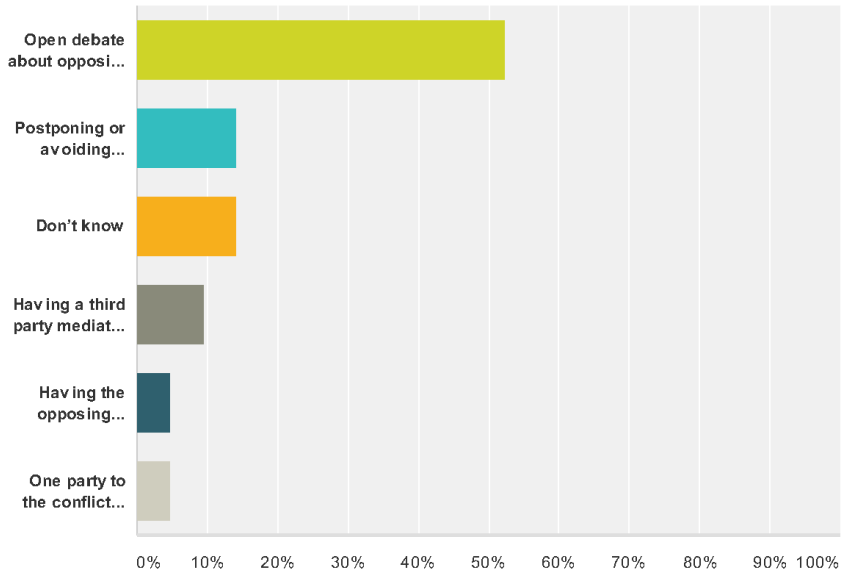
Q14 How much conflict within the RPC was caused by each of the following factors?

Answered: 22 Skipped: 9

	None	Some	A lot	Dont Know	Total	Average Rating
Differences in opinion about the best strategies to achieve RPC goals and objectives	13.64% 3	63.64% 14	4.55% 1	18.18% 4	22	1.00
Personality clashes	22.73% 5	50.00% 11	0.00% 0	27.27% 6	22	1.00
Clashes among RPC members, Sierra Health Foundation: Center for Health Program Management , Sacramento County Division of Behavioral Health Services (DBHS), and/or the RPC facilitator	27.27% 6	40.91% 9	4.55% 1	27.27% 6	22	1.00
Fighting for resources	50.00% 11	27.27% 6	4.55% 1	18.18% 4	22	1.00
Differences in opinion about who gets public exposure and recognition	50.00% 11	27.27% 6	0.00% 0	22.73% 5	22	1.00
Procedures used for completing the work	36.36% 8	36.36% 8	4.55% 1	22.73% 5	22	1.00
Members aren't sufficiently included in RPC processes/decision-making	54.55% 12	31.82% 7	0.00% 0	13.64% 3	22	1.00
Members haven't completed their tasks or assignments before meetings	9.09% 2	54.55% 12	13.64% 3	22.73% 5	22	1.00
Members are not sufficiently prepared to make decisions at meetings	4.55% 1	63.64% 14	13.64% 3	18.18% 4	22	1.00
Member(s) who dominate the RPC meetings and impede proper collaboration	36.36% 8	50.00% 11	0.00% 0	13.64% 3	22	1.00

Q15 Please select the main strategy the RPC has used to address conflicts that occur. (Select only one)

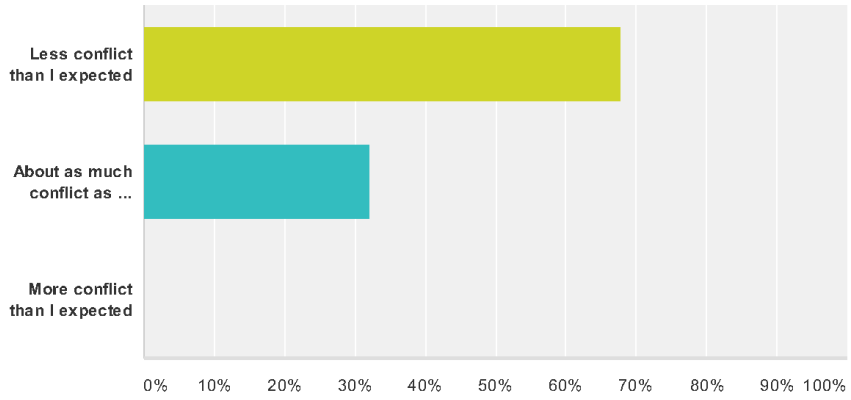
Answered: 21 Skipped: 10



Answer Choices	Responses	
Open debate about opposing viewpoints	52.38%	11
Postponing or avoiding discussions of controversial issues	14.29%	3
Don't know	14.29%	3
Having a third party mediate between those with opposing viewpoints	9.52%	2
Having the opposing parties negotiate directly with each other	4.76%	1
One party to the conflict gives in	4.76%	1
Total		21

Q16 Select the response that represents the amount of conflict in the RPC.

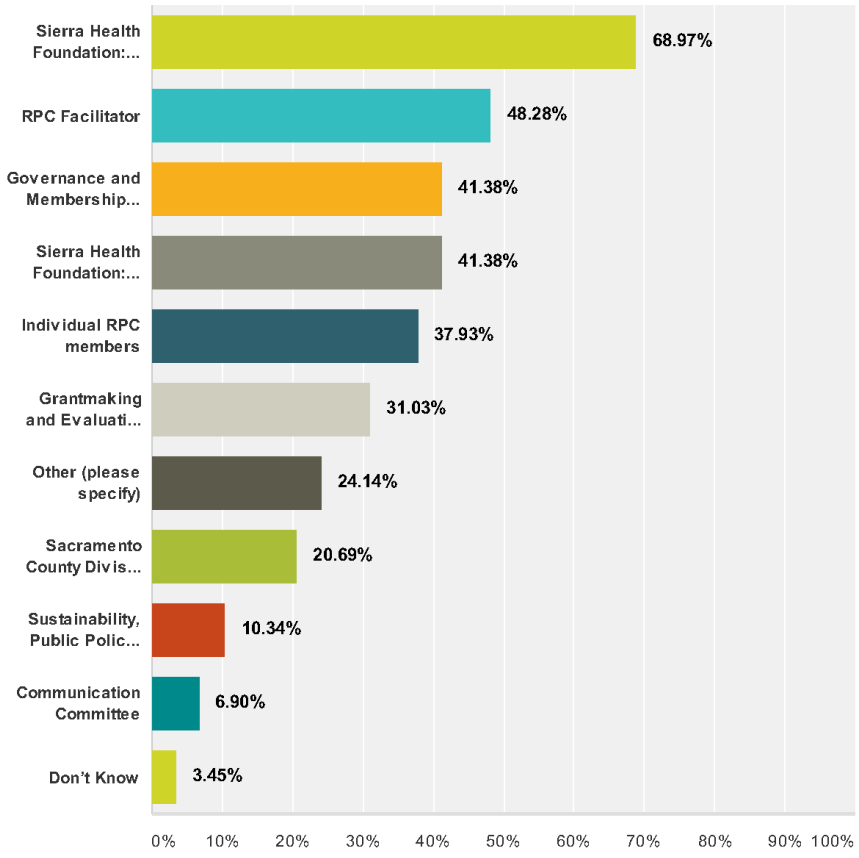
Answered: 28 Skipped: 3



Answer Choices	Responses	
Less conflict than I expected	67.86%	19
About as much conflict as I expected	32.14%	9
More conflict than I expected	0.00%	0
Total		28

Q17 Who provides leadership for the RPC? (Select all that apply)

Answered: 29 Skipped: 2



Answer Choices	Responses
Sierra Health Foundation: Center for Health Program Management and the Sacramento County Division of Behavioral Health Services (DBHS) provide leadership together	68.97% 20
RPC Facilitator	48.28% 14
Governance and Membership Committee	41.38% 12
Sierra Health Foundation: Center for Health Program Management	41.38% 12
Individual RPC members	37.93% 11

Grantmaking and Evaluation Committee	**31.03%**	9
Other (please specify)	**24.14%**	7
Sacramento County Division of Behavioral Health Services (DBHS)	**20.69%**	6
Sustainability, Public Policy, and Collaboration Committee	**10.34%**	3
Communication Committee	**6.90%**	2
Don't Know	**3.45%**	1
Total Respondents: 29		

#	Other (please specify)	Date
1	Have noticed that the Goverance and Grantmaking Committes are making more decsions now that are providing leadership	11/22/2013 9:06 AM
2	Planning Committee	11/21/2013 11:18 AM
[redacted]	[redacted]	[redacted]
4	I don't know if the Committees are taking a more active role this year, but last year they were not exactly functioning in a leadership capacity	11/19/2013 7:51 AM
5	do not feel like RPC has influlance over final funding decisions	11/17/2013 10:26 AM
6	Sierra Health Foundation Center for Health Program Officer	11/15/2013 1:04 PM
7	everyone	11/13/2013 4:52 PM

Q18 If you have selected multiple choices in the question above, please select the SINGLE choice you think provides the most leadership for the RPC. Write your choice in this box:

Answered: 22 Skipped: 9

#	Responses	Date
1	Sustainability, Public Policy, and Collaboration Committee	2/19/2014 2:33 PM
2	Sierra Health Foundation: Center for Health Program Management and the Sacramento County Division of Behavioral Health Services (DBHS) provide leadership together	1/7/2014 1:35 PM
3	Center for Health Program Management	12/20/2013 1:36 PM
4	Sierra Health Foundation: Center for Health Program Management and the Sacramento County Division of Behavioral Health Services (DBHS) provide leadership together	12/17/2013 4:49 PM
5	SHF/DBHS together	11/26/2013 3:55 PM
6	The Center and DBHS	11/26/2013 7:42 AM
7	Sierra Health Foundation RPC Facilitator	11/22/2013 9:06 AM
8	Sac County and Sierra Health Foundation	11/22/2013 8:16 AM
9	Planning Committee	11/21/2013 11:18 AM
10	Sierra Health Foundation	11/21/2013 11:10 AM
11	Individual RPC Members w/ help from SHF/DBHS as requested	11/21/2013 12:11 AM
12	Sierra Health and DBHS	11/20/2013 2:16 PM
13	Center for Health Program and Management &DBHS	11/19/2013 6:08 PM
14	FACILITATOR	11/19/2013 2:17 PM
15	Sierra Health, DBHS, etc	11/19/2013 7:51 AM
16	SHF & DBHS	11/18/2013 12:08 PM
17	SHF DBHS	11/17/2013 10:26 AM
18	Don't Know	11/15/2013 1:04 PM
19	SHF	11/14/2013 2:23 PM
20	Sierra Health Foundation	11/14/2013 1:02 AM
21	Individual RPC members	11/13/2013 4:52 PM
22	Sierra Health and Sac County DBHS	11/13/2013 4:43 PM

Q19 Please select how much you agree or disagree with each statement.

Answered: 29 Skipped: 2

	Disagree	Agree	Don't Know	Total	Average Rating
Sacramento County Division of Behavioral Health Services (DBHS), Sierra Health Foundation: Center for Health Program Management, and RPC members work collaboratively	3.45% 1	93.10% 27	3.45% 1	29	1.00
The work of the paid staff supports the work of the RPC	3.45% 1	89.66% 26	6.90% 2	29	1.00
The RPC utilizes the skills and talents of many, not just a few	6.90% 2	86.21% 25	6.90% 2	29	1.00
RPC members take responsibility for getting the work done	10.34% 3	82.76% 24	6.90% 2	29	1.00
The RPC has appropriate balance of responsibility between Sacramento County Division of Behavioral Health Services (DBHS), Sierra Health Foundation: Center for Health Program Management , and RPC members	34.48% 10	58.62% 17	6.90% 2	29	1.00

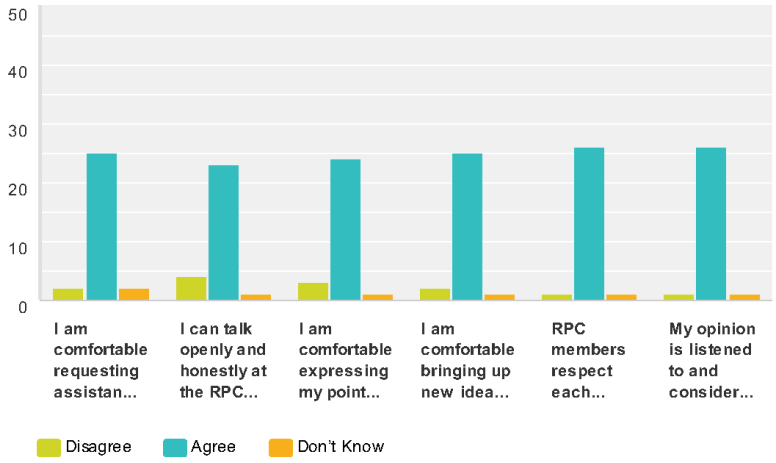
Q20 Please indicate how well defined the roles are for each of the following parties.

Answered: 28 Skipped: 3

	Not well defined	Somewhat defined	Very well defined	Don't Know	Total	Average Rating
Communication Committee	35.71% 10	25.00% 7	17.86% 5	21.43% 6	28	1.00
Governance and Membership Committee	0.00% 0	28.57% 8	60.71% 17	10.71% 3	28	1.00
Grantmaking and Evaluation Committee	0.00% 0	17.86% 5	71.43% 20	10.71% 3	28	1.00
Sustainability, Public Policy, and Collaboration Committee	10.71% 3	35.71% 10	28.57% 8	25.00% 7	28	1.00
RPC facilitator	0.00% 0	10.71% 3	78.57% 22	10.71% 3	28	1.00
Sacramento County Division of Behavioral Health Services (DBHS)	7.14% 2	7.14% 2	67.86% 19	17.86% 5	28	1.00
Sierra Health Foundation: Center for Health Program Management	0.00% 0	3.57% 1	85.71% 24	10.71% 3	28	1.00

Q21 Please select how much you agree or disagree with the following statements.

Answered: 29 Skipped: 2



	Disagree	Agree	Don't Know	Total	Average Rating
I am comfortable requesting assistance from the other RPC members when I feel their input could be of value	**6.90%** 2	**86.21%** 25	**6.90%** 2	29	1.00
I can talk openly and honestly at the RPC meetings	**14.29%** 4	**82.14%** 23	**3.57%** 1	28	1.00
I am comfortable expressing my point of view even if other RPC members might disagree	**10.71%** 3	**85.71%** 24	**3.57%** 1	28	1.00
I am comfortable bringing up new ideas at RPC meetings	**7.14%** 2	**89.29%** 25	**3.57%** 1	28	1.00
RPC members respect each others' points of view even if they might disagree	**3.57%** 1	**92.86%** 26	**3.57%** 1	28	1.00
My opinion is listened to and considered by other members	**3.57%** 1	**92.86%** 26	**3.57%** 1	28	1.00

Q22 Please indicate how much you agree or disagree with the following statements.

Answered: 29 Skipped: 2

	Disagree	Agree	Don't Know	Total	Average Rating
Sacramento County Division of Behavioral Health Services (DBHS) is respected by others in the RPC	3.45% 1	93.10% 27	3.45% 1	29	1.00
Sierra Health Foundation: Center for Health Program Management is respected by others in the RPC	0.00% 0	93.10% 27	6.90% 2	29	1.00
RPC facilitator is respected by others in the RPC	6.90% 2	89.66% 26	3.45% 1	29	1.00
The RPC is respected in the community	10.34% 3	24.14% 7	65.52% 19	29	1.00

Q23 Please select how much you agree or disagree with the following statements.

Answered: 29 Skipped: 2

	Disagree	Agree	Don't Know	Total	Average Rating
The RPC agrees on the strategies it should use in pursuing its priorities	17.24% 5	75.86% 22	6.90% 2	29	1.00
The RPC has a clear and shared understanding of the problems we are trying to address	13.79% 4	82.76% 24	3.45% 1	29	1.00
There is a general agreement with respect to the mission of the RPC	3.45% 1	93.10% 27	3.45% 1	29	1.00
The RPC charter clearly defines the roles, responsibilities and timelines for conducting the activities that work towards achieving the stated mission of the RPC	3.45% 1	86.21% 25	10.34% 3	29	1.00

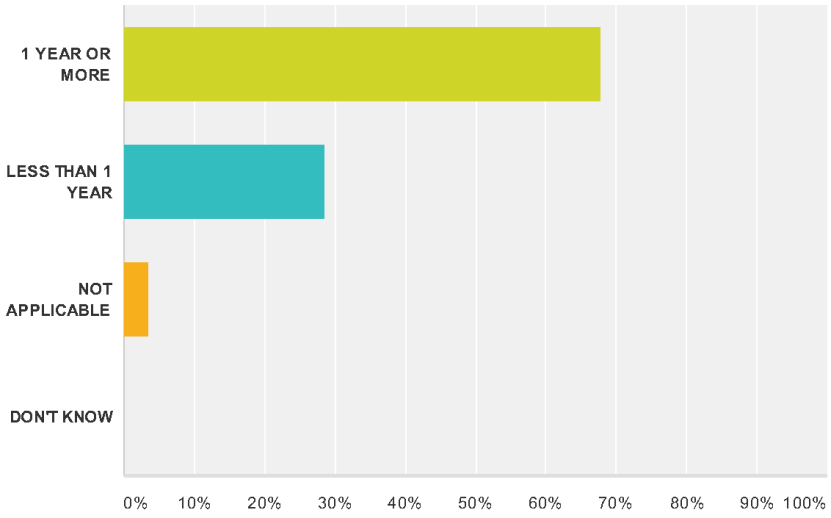
Q24 Please select whether the following functions are major, minor, not a function, or you don't know. The functions of the RPC are to:

Answered: 28 Skipped: 3

	Not a Function	A Minor Function	A Major Function	Don't Know	Total	Average Rating
Network with other professionals	3.70% 1	51.85% 14	44.44% 12	0.00% 0	27	1.00
Network with concerned citizens	7.14% 2	42.86% 12	42.86% 12	7.14% 2	28	1.00
Conduct strategic planning	7.14% 2	25.00% 7	57.14% 16	10.71% 3	28	1.00
Make decisions about priority needs and problems	0.00% 0	22.22% 6	77.78% 21	0.00% 0	27	1.00
Recommend or make decisions to allocate resources	0.00% 0	0.00% 0	100.00% 28	0.00% 0	28	1.00
Operate particular programs or activities	71.43% 20	17.86% 5	7.14% 2	3.57% 1	28	1.00
Advocate for local public policy objectives	25.00% 7	39.29% 11	28.57% 8	7.14% 2	28	1.00
Advocate for state public policy objectives	25.00% 7	50.00% 14	14.29% 4	10.71% 3	28	1.00
Provide funding for programs	7.14% 2	7.14% 2	82.14% 23	3.57% 1	28	1.00
Raise funds to sustain long-term RPC activities	42.86% 12	32.14% 9	14.29% 4	10.71% 3	28	1.00

Q25 How long have you been part of the RPC?

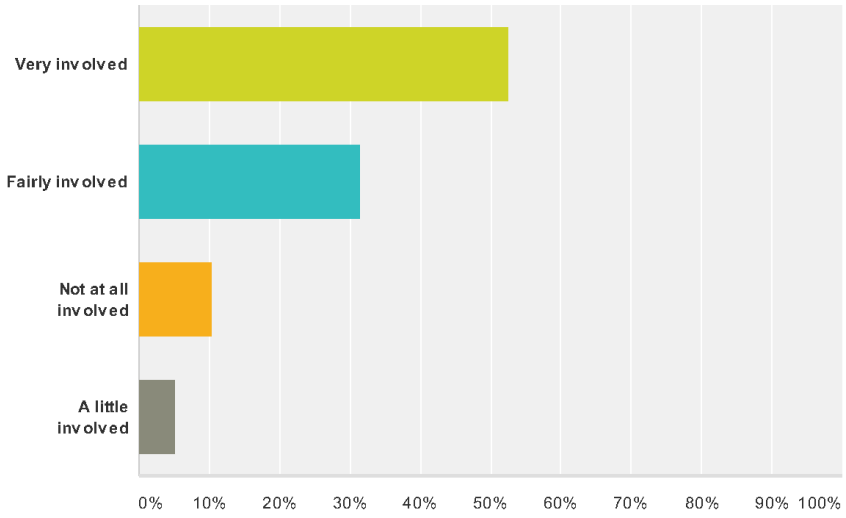
Answered: 28 Skipped: 3



Answer Choices	Responses	
1 YEAR OR MORE	**67.86%**	19
LESS THAN 1 YEAR	**28.57%**	8
NOT APPLICABLE	**3.57%**	1
DON'T KNOW	**0.00%**	0
Total		**28**

Q26 Over the past year, how involved have you been in RPC activities?

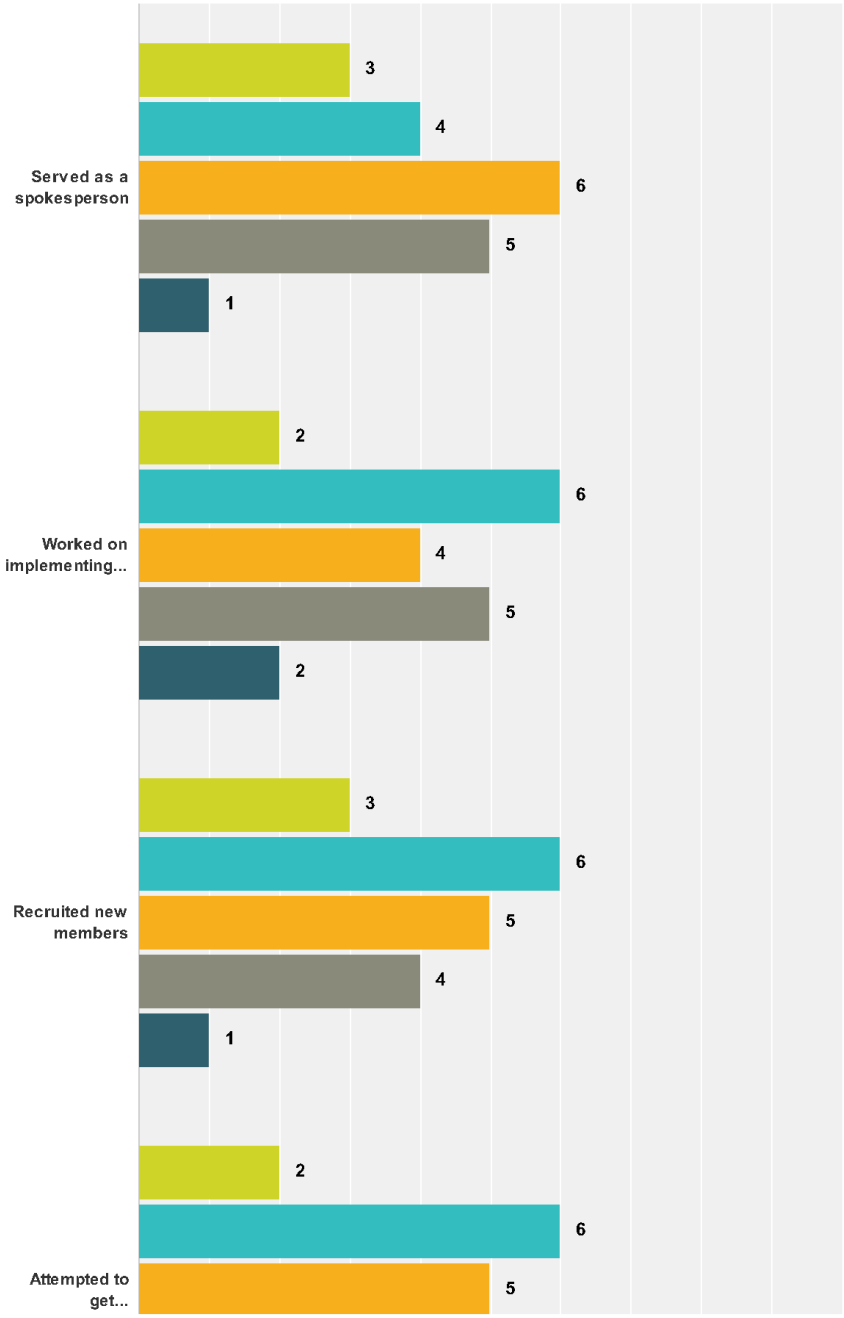
Answered: 19 Skipped: 12



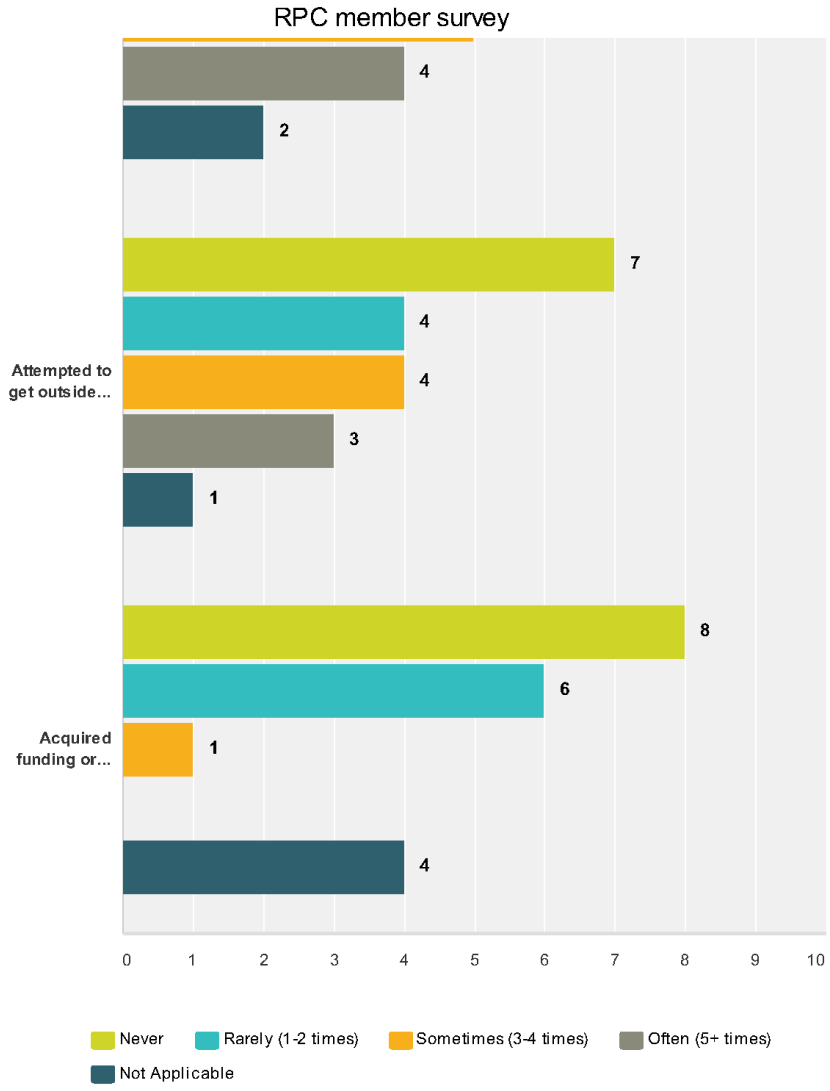
Answer Choices	Responses	
Very involved	52.63%	10
Fairly involved	31.58%	6
Not at all involved	10.53%	2
A little involved	5.26%	1
Total		19

Q27 Please select how many times over the last year you personally have done the following for the RPC, by # of respondents:

Answered: 19 Skipped: 12



28 / 47

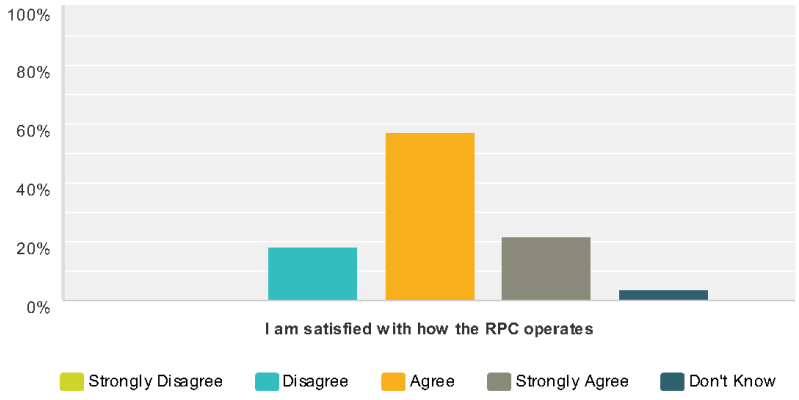


	Never	Rarely (1-2 times)	Sometimes (3-4 times)	Often (5+ times)	Not Applicable	Total	Average Rating
Served as a spokesperson	**15.79%** 3	**21.05%** 4	**31.58%** 6	**26.32%** 5	**5.26%** 1	19	1.00
Worked on implementing activities or events sponsored by the RPC (other than RPC meetings)	**10.53%** 2	**31.58%** 6	**21.05%** 4	**26.32%** 5	**10.53%** 2	19	1.00
Recruited new members	**15.79%** 3	**31.58%** 6	**26.32%** 5	**21.05%** 4	**5.26%** 1	19	1.00
Attempted to get organizations to submit proposals for funding	**10.53%** 2	**31.58%** 6	**26.32%** 5	**21.05%** 4	**10.53%** 2	19	1.00
Attempted to get outside support for RPC positions on key issues	**36.84%** 7	**21.05%** 4	**21.05%** 4	**15.79%** 3	**5.26%** 1	19	1.00

Acquired funding or other resources for the RPC	**42.11%** 8	**31.58%** 6	**5.26%** 1	**0.00%** 0	**21.05%** 4	19	1.00

Q28 Please select how much you agree or disagree with the following statement:

Answered: 28 Skipped: 3



	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total	Average Rating
I am satisfied with how the RPC operates	**0.00%** 0	**17.86%** 5	**57.14%** 16	**21.43%** 6	**3.57%** 1	28	1.00

Q29 Please select to what extent each of the following has been a benefit to your participation on the RPC.

Answered: 27 Skipped: 4

	No Benefit	A Little Benefit	Some Benefit	Great Benefit	Not Applicable	Total	Average Rating
Increasing my professional skills and knowledge	3.70% 1	14.81% 4	37.04% 10	29.63% 8	14.81% 4	27	1.00
Developing personal connections with individual RPC members	0.00% 0	14.81% 4	25.93% 7	51.85% 14	7.41% 2	27	1.00
Getting access to key organizations	25.93% 7	14.81% 4	37.04% 10	14.81% 4	7.41% 2	27	1.00
Developing professional networks with key organizations	14.81% 4	37.04% 10	11.11% 3	25.93% 7	11.11% 3	27	1.00
Getting access to key policy makers	37.04% 10	18.52% 5	11.11% 3	14.81% 4	18.52% 5	27	1.00
Developing collaborative relationships with key policy makers	33.33% 9	14.81% 4	11.11% 3	18.52% 5	22.22% 6	27	1.00
Increasing my sense that others share my goals and concerns	3.70% 1	18.52% 5	25.93% 7	44.44% 12	7.41% 2	27	1.00
Getting support for policy issues I feel strongly about	25.93% 7	14.81% 4	22.22% 6	18.52% 5	18.52% 5	27	1.00
Giving back to my community	0.00% 0	7.69% 2	15.38% 4	61.54% 16	15.38% 4	26	1.00

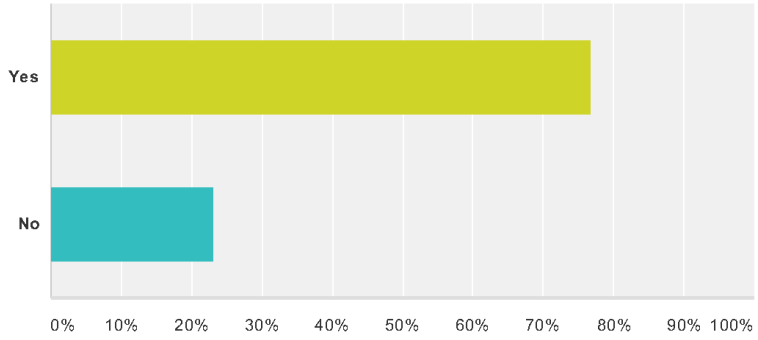
Q30 Please select to what extent each of the following have been problems for your participation in the RPC.

Answered: 27 Skipped: 4

	No Problem	Minor Problem	A Major Problem	Not Applicable	Total	Average Rating
RPC activities do not reach my primary constituency	29.63% 8	25.93% 7	22.22% 6	22.22% 6	27	1.00
Working on the RPC doesn't get me or my organization enough public recognition	51.85% 14	11.11% 3	3.70% 1	33.33% 9	27	1.00
My skills and time are not well-used	55.56% 15	25.93% 7	7.41% 2	11.11% 3	27	1.00
My opinion is not valued	74.07% 20	3.70% 1	7.41% 2	14.81% 4	27	1.00
The RPC is not taking any meaningful action	55.56% 15	25.93% 7	0.00% 0	18.52% 5	27	1.00
I am often the only voice representing my viewpoint	44.44% 12	22.22% 6	11.11% 3	22.22% 6	27	1.00
There are too many meetings	48.15% 13	33.33% 9	7.41% 2	11.11% 3	27	1.00
Meetings are too long	55.56% 15	22.22% 6	11.11% 3	11.11% 3	27	1.00
The time commitments for RPC activities outside of meetings are too high	37.04% 10	40.74% 11	3.70% 1	18.52% 5	27	1.00
The financial burden of being part of the RPC is too high	62.96% 17	11.11% 3	3.70% 1	22.22% 6	27	1.00
The RPC is competing with other groups with similar missions	66.67% 18	7.41% 2	3.70% 1	22.22% 6	27	1.00
There is a conflict of interest between my organization and the work of the RPC	70.37% 19	3.70% 1	3.70% 1	22.22% 6	27	1.00

Q31 In your experience, do the benefits of participation in the RPC appear to outweigh the costs to you at this point?

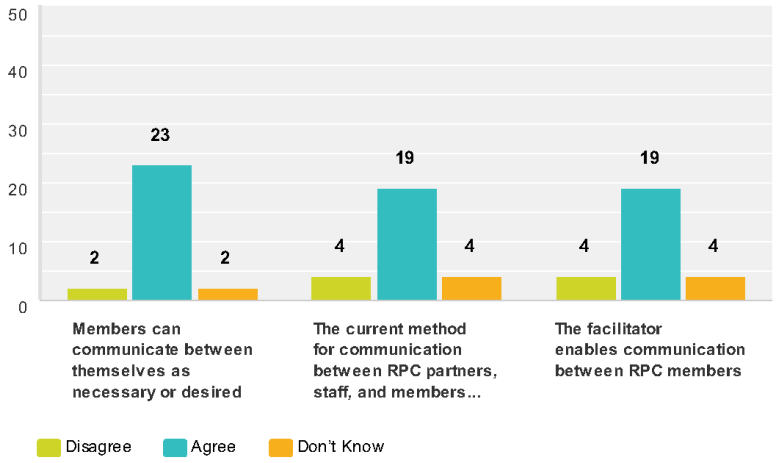
Answered: 26 Skipped: 5



Answer Choices	Responses	
Yes	76.92%	20
No	23.08%	6
Total		26

Q32 Please select how much you agree or disagree with the following statements.

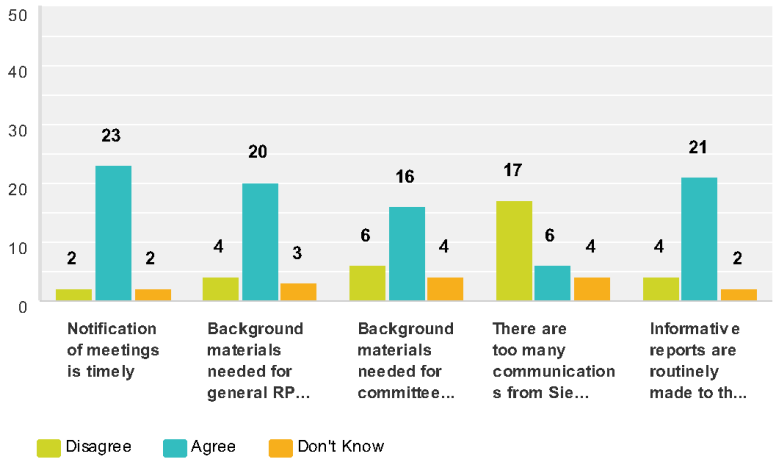
Answered: 27 Skipped: 4



	Disagree	Agree	Don't Know	Total	Average Rating
Members can communicate between themselves as necessary or desired	7.41% 2	85.19% 23	7.41% 2	27	1.00
The current method for communication between RPC partners, staff, and members is effective	14.81% 4	70.37% 19	14.81% 4	27	1.00
The facilitator enables communication between RPC members	14.81% 4	70.37% 19	14.81% 4	27	1.00

Q33 Please select how much you agree or disagree with the following statements, by # of respondents

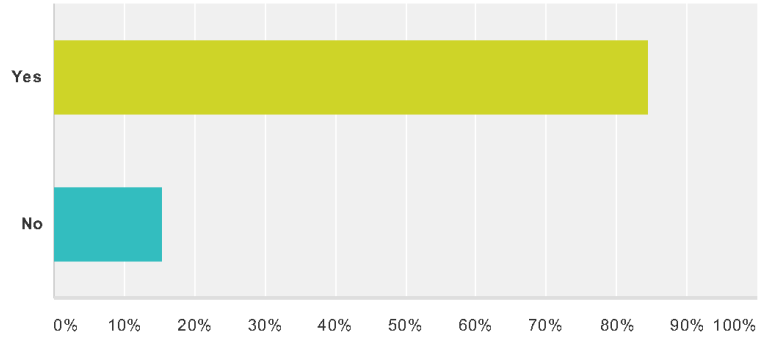
Answered: 27 Skipped: 4



	Disagree	Agree	Don't Know	Total	Average Rating
Notification of meetings is timely	7.41% 2	85.19% 23	7.41% 2	27	1.00
Background materials needed for general RPC meetings are prepared & distributed in a timely way before meetings (agendas, minutes, study documents)	14.81% 4	74.07% 20	11.11% 3	27	1.00
Background materials needed for committee meetings are prepared & distributed in a timely way before meetings (agendas, minutes, study documents)	23.08% 6	61.54% 16	15.38% 4	26	1.00
There are too many communications from Sierra Health Foundation: Center for Health Program Management	62.96% 17	22.22% 6	14.81% 4	27	1.00
Informative reports are routinely made to the entire RPC	14.81% 4	77.78% 21	7.41% 2	27	1.00

Q34 Do you feel you have adequate knowledge about respite care services to function effectively in the RPC?

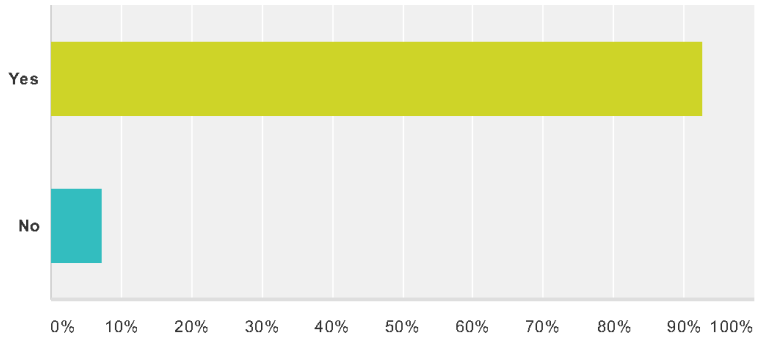
Answered: 26 Skipped: 5



Answer Choices	Responses	
Yes	84.62%	22
No	15.38%	4
Total		26

Q35 Has the RPC helped you learn more about respite care services?

Answered: 27 Skipped: 4



Answer Choices	Responses	
Yes	92.59%	25
No	7.41%	2
Total		27

Q36 How do you define respite care services?

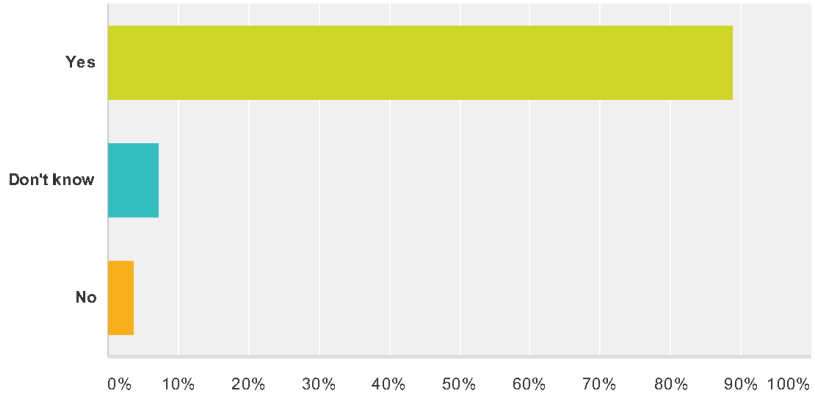
Answered: 19 Skipped: 12

#	Responses	Date
1	A time out for self care and connections to others to reduce stressors and crises and increase social networks and coping skills/community supports/in lieu of hospitalization or other serious consequences resulting from exceeding ones coping capacity.	2/19/2014 2:37 PM
2	Providing a break or alternative services to person experiencing mental health crises before needing or in place of hospitalization or Emergency Department	1/7/2014 1:45 PM
3	I generally define respite care services as being crisis respite for the individual going through them. I think a huge barrier to receiving care is the thought and fear of emergency psychiatric services. When someone is in crisis they need a place that is a step between emergency care and non-crisis care. It would be great if they can rely on trained peers for these services, people who understand what they are going through and can positively support a good outcome, rather than serve with intimidation, which has so often been the case.	12/30/2013 3:10 PM
4	Broadly. Those in need of respite services or those family members of those in need of respite services.	12/20/2013 2:07 PM
5	A service that provides relief from every day stresses	12/17/2013 4:56 PM
6	In the context of mental health, it is a "time out" that will help a person in crisis stabilize and avoid more intensive intervention such as psychiatric hospitalization. Respite may also be for a family member of a mental health consumer.	11/26/2013 4:04 PM
7	Planned and programmed time of respite (break in routine to rest, recuperate, and regroup) for caretakers and/or consumers	11/22/2013 9:45 AM
8	A multitude of service available in the community. there have been surprises in how respite so it's hard to make a single definition. I'll say at least that it encompases the ability to provide a much needed break for various persons in the community much of which gives the relief necessary to mitigate the crisis situations that would occur without the many innovative plans proposed and funded.	11/22/2013 8:34 AM
9	respite services provide a break for consumers experiencing a mental health crisis or to prevent a mental health crisis.	11/21/2013 1:20 PM
10	Respite is a time out in s safe environement for an indivudal in distress to regain needed internal resources to function as they normally do	11/21/2013 11:27 AM
11	Immediate help for people in a crisis (they are always temporary) a crisis is a situation where people find themselves unable to manage their own lives or situations and need help and a break from it.	11/21/2013 12:25 AM
12	Effective intervention at mezzo and micro level. At the micro level prevent escalation of crisis, waiting time at ER, and at mezzo level decrease psychiatric hospitalization and other forms of decompensating	11/19/2013 6:18 PM
13	Respite care is a "time out" from dealing with the stress of issues affecting ones everyday life by providing a safe place for people to go and seek help, rest or whatever is needed to reduce their individual challages	11/19/2013 2:30 PM
14	Deescalation and stabilization to avoid hospitalization from mental health crisis	11/19/2013 7:58 AM
15	Services available to help someone "take a break" from the stress of their lives - can be planned/unplanned	11/18/2013 12:16 PM
16	giving family members a break from providing for their loved ones	11/17/2013 10:39 AM
17	An opportunity for a person in crisis to have time away from the stress of their daily lives where they can find support from professionals and/or peers.	11/14/2013 1:13 AM

18	A break (mentally or physically) to provide a person the time to maintain his/her mental health. Please note that Respite Services may look differently or be delivered differently depending on the group, culture, or social norms/construct. Respite should be defined by who is serviced. What I consider respite may not be a break for another. I do not believe there is one cookie cutter answer to respite care services.	11/13/2013 5:11 PM
19	Respite gives either family member or consumer a break ~ that can look many, many different ways. It can be before, during or after crisis. It can be formal or informal, planned or emergency.	11/13/2013 5:04 PM

Q37 Has the RPC been responsible for activities or programs that otherwise would not have occurred?

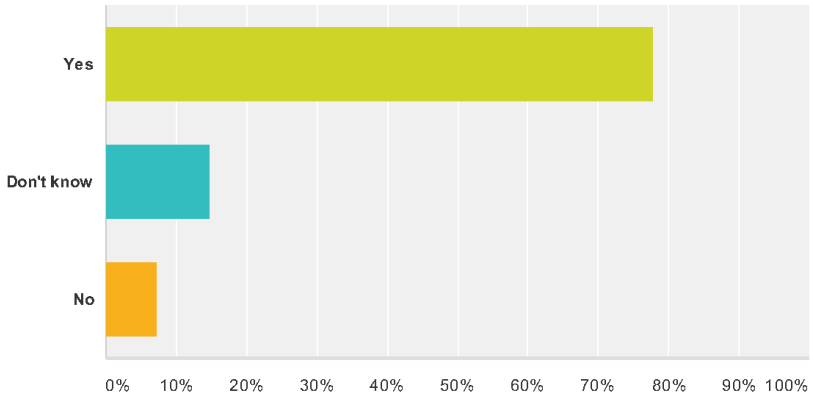
Answered: 27 Skipped: 4



Answer Choices	Responses	
Yes	88.89%	24
Don't know	7.41%	2
No	3.70%	1
Total		27

Q38 Has the RPC brought benefit to your community?

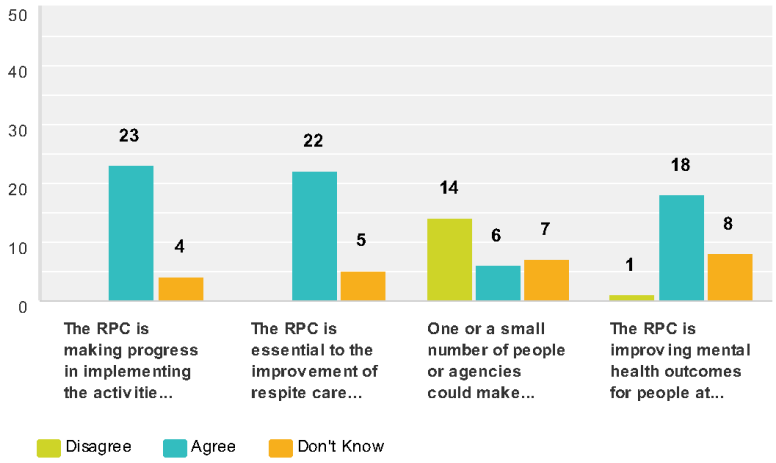
Answered: 27 Skipped: 4



Answer Choices	Responses	
Yes	77.78%	21
Don't know	14.81%	4
No	7.41%	2
Total		27

Q39 Please select how much you agree or disagree with the following statements, by # of respondents

Answered: 27 Skipped: 4



	Disagree	Agree	Don't Know	Total	Average Rating
The RPC is making progress in implementing the activities that have potential to improve respite care services.	0.00% 0	85.19% 23	14.81% 4	27	1.00
The RPC is essential to the improvement of respite care services in Sacramento County	0.00% 0	81.48% 22	18.52% 5	27	1.00
One or a small number of people or agencies could make significant progress in respite care services without the RPC	51.85% 14	22.22% 6	25.93% 7	27	1.00
The RPC is improving mental health outcomes for people at risk of experiencing crises.	3.70% 1	66.67% 18	29.63% 8	27	1.00

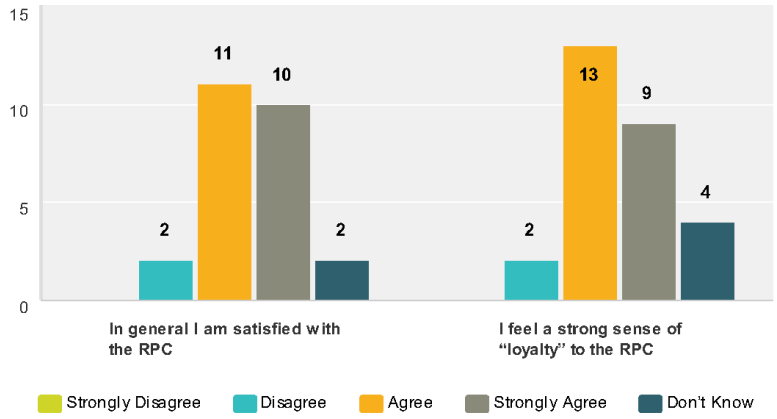
Q40 Please select how much you agree or disagree with the following statements.

Answered: 27 Skipped: 4

	Disagree	Agree	Don't Know	Total	Average Rating
The RPC is making plans to continue operating after current funding is terminated	11.11% 3	55.56% 15	33.33% 9	27	1.00
The RPC has begun to find resources to continue operating after current funding is terminated	37.04% 10	18.52% 5	44.44% 12	27	1.00
Resources are being identified to support the systemic, programmatic changes implemented through the work of the RPC	18.52% 5	25.93% 7	55.56% 15	27	1.00
The RPC will continue to exist beyond the MHSA funding period	7.41% 2	11.11% 3	81.48% 22	27	1.00
The RPC is helping grantees to continue offering respite services after their RPC funding ends	22.22% 6	22.22% 6	55.56% 15	27	1.00

Q41 Please select how much you agree or disagree with the following statements.

Answered: 28 Skipped: 3



	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total	Average Rating
In general I am satisfied with the RPC	0.00% 0	8.00% 2	44.00% 11	40.00% 10	8.00% 2	25	1.00
I feel a strong sense of "loyalty" to the RPC	0.00% 0	7.14% 2	46.43% 13	32.14% 9	14.29% 4	28	1.00

Q42 What issues should the RPC be paying more attention to?

Answered: 18 Skipped: 13

#	Responses	Date
1	Building capacity and program design/evaluation via TA of community defined models likely to have great impact rather than to dismiss there potential because they did not describe their model a certain way. Give people opportunities to clarify areas where questions arise. I had a disappointing experience with my application for funding for our nonprofit where I had witnessed other applicants receiving opportunity to answer questions to clarify the models rather than being disqualified for funding. I see these capacity, planning, design, and program barriers and leadership training keep African American grassroots programs from getting the support they need to be successful all the time. It's unfortunate.	2/19/2014 2:40 PM
2	Policy and sustainability. Community programs and accomplishments to general public and key policy makers	1/7/2014 1:47 PM
3	Sustainability and even before that supporting education in the community around crisis respite. Shoring up the peer communities with a number of cultures throughout various neighborhoods, serving a variety of demographic groups. Knowledge about funding and licensing is critical to the success of the groups who have an interest in funding crisis respite.	12/30/2013 3:24 PM
4	Sustainability	12/20/2013 2:13 PM
5	Sustainability	12/20/2013 10:48 AM
6	The big picture of creating a collaborative vehicle to advance their goal of providing respite services within a continuum of care in order to reduce psychiatric hospitalizations. What will remain when the funding is gone? Building relationships and support for their vision is essential.	11/26/2013 4:11 PM
7	There is an influx of MHSA money coming into the county that could possibly be used for sustainability. Also grants need to be investigated more to help with sustainability of effective RPC programs. After evaluation of the most effective programs, we need to be focusing on sustainability for them. Otherwise all our work will only be a flash of help for the county, not one that consumers and caretakers can count on for help.	11/22/2013 9:54 AM
8	Out reach to deaf community and populations of color who subsist in poverty.	11/22/2013 8:37 AM
9	focusing work and energy on project as defined (rather than broadening scope)	11/21/2013 1:46 PM
10	What would it take to sustain the RPC and respite programs, (i.e. what are the associated costs)	11/21/2013 11:31 AM
11	Helping those collaborations develop that are going to be so essential to respite operators after the 5 year lifespan of the RPC	11/21/2013 12:42 AM
12	Sustainability of services	11/19/2013 2:33 PM
13	See below	11/19/2013 8:02 AM
14	Sustainability and policy issues	11/18/2013 12:18 PM
15	Law enforcement training Juvenile Justice Faith based	11/17/2013 10:42 AM
16	Dialogue on planned respite vs crisis respite. Should we place equal emphasis on prevention and education?	11/14/2013 1:19 AM
17	Time management if possible, continue to look at statistics, look at respite services that work, and continue innovative ideas	11/13/2013 5:22 PM
18	sustainbiltiy of funded programs.	11/13/2013 5:06 PM

Q43 Are there any critical events over the past year that have had an impact on the RPC? Please describe.

Answered: 12 Skipped: 19

#	Responses	Date
1	Not sure, I literally was so discouraged I stopped participating. I wish them well, however and enjoyed the opportunity to contribute.	2/19/2014 2:40 PM
2	New funding through a bill that passed regarding crisis care. The need to have that funding coexist with RPC funding to make a bigger difference.	12/30/2013 3:24 PM
3	Not that I am aware of. Maybe the mental health dollars that are coming down can be tapped into it.	12/20/2013 2:13 PM
[redacted]	[redacted]	[redacted]
5	More funds coming into the county	11/22/2013 9:54 AM
6	tragedies highlighted in the media have put a lot of focus on the need for mental health crisis services	11/21/2013 1:46 PM
[redacted]	[redacted]	[redacted]
8	The granting of funds and the results	11/19/2013 2:33 PM
9	Implementation of the ACA and mental health coverage/outreach to enroll	11/19/2013 8:02 AM
10	awarding of grants that has made a better community	11/17/2013 10:42 AM
11	Number of murders that have involved residents with mental health problems eg Russian family locally and Newtown and Colorado nationally to name two.	11/14/2013 1:19 AM
12	New RPC members I think have made the group more cohesive and the new group seem to genuinely listen to one another's opinions. Watching the progress of our grantees also has continue to motivate RPC and gives each member passion to do the work we do.	11/13/2013 5:22 PM

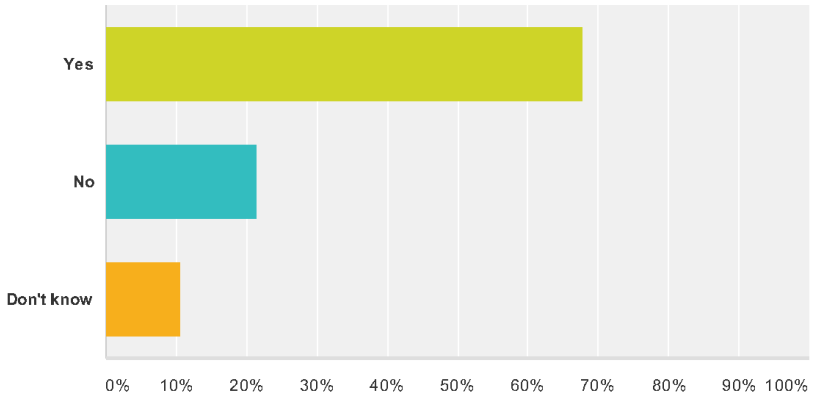
Appendix D. Community Survey Results

Community Survey Results

RPC Community Survey

Q1 Have you ever heard of the Respite Partnership Collaborative, or RPC?

Answered: 28 Skipped: 0



Answer Choices	Responses	
Yes	67.86%	19
No	21.43%	6
Don't know	10.71%	3
Total		28

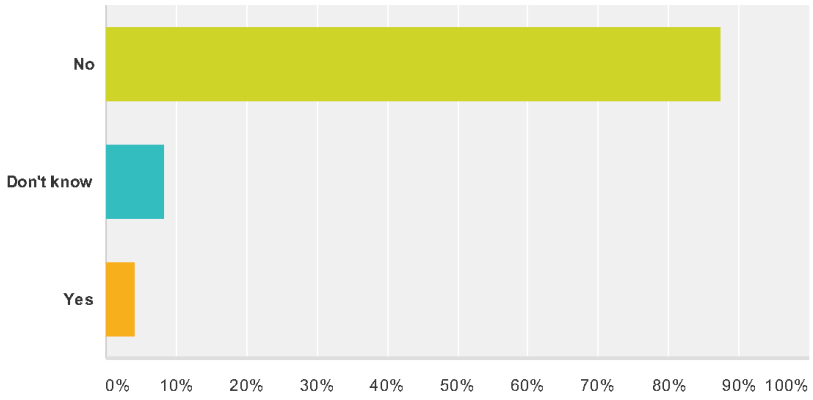
Q2 Please select whether the following functions are major, minor, not a function, or you don't know. The functions of the RPC are to:

Answered: 27 Skipped: 1

	Not a Function	A Minor Function	A Major Function	Don't Know	Total	Average Rating
Network with other professionals	**11.54%** 3.0	**30.77%** 8.0	**38.46%** 10.0	**19.23%** 5.0	26	1.00
Network with concerned citizens	**3.85%** 1.0	**53.85%** 14.0	**23.08%** 6.0	**19.23%** 5.0	26	1.00
Conduct strategic planning	**7.69%** 2.0	**19.23%** 5.0	**50.00%** 13.0	**23.08%** 6.0	26	1.00
Make decisions about priority needs and problems	**7.69%** 2.0	**3.85%** 1.0	**65.38%** 17.0	**23.08%** 6.0	26	1.00
Recommend or make decisions to allocate resources	**12.00%** 3.0	**4.00%** 1.0	**64.00%** 16.0	**20.00%** 5.0	25	1.00
Operate particular programs or activities	**26.92%** 7.0	**30.77%** 8.0	**19.23%** 5.0	**23.08%** 6.0	26	1.00
Advocate for local public policy objectives	**19.23%** 5.0	**34.62%** 9.0	**23.08%** 6.0	**23.08%** 6.0	26	1.00
Advocate for state public policy objectives	**20.00%** 5.0	**44.00%** 11.0	**12.00%** 3.0	**24.00%** 6.0	25	1.00
Provide funding for programs	**22.22%** 6.0	**11.11%** 3.0	**40.74%** 11.0	**25.93%** 7.0	27	1.00
Raise funds to sustain long-term RPC activities	**25.93%** 7.0	**18.52%** 5.0	**18.52%** 5.0	**37.04%** 10.0	27	1.00

Q3 Have you ever applied to become a member of the RPC?

Answered: 24 Skipped: 4



Answer Choices	Responses	
No	**87.50%**	21
Don't know	**8.33%**	2
Yes	**4.17%**	1
Total		**24**

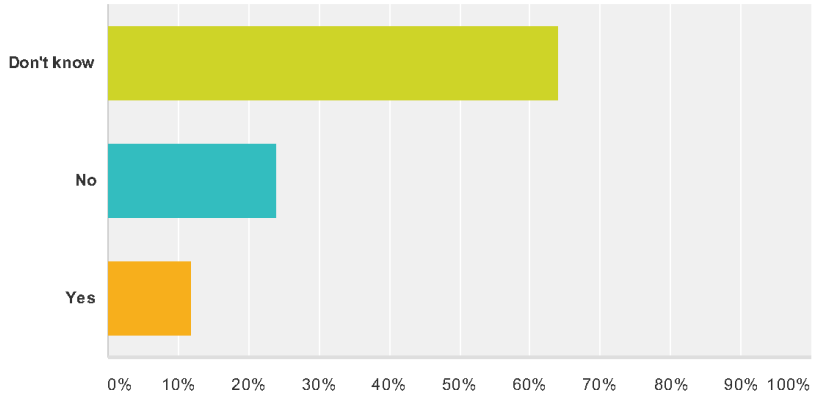
Q4 Please whether the following options have been not at all a factor, a minor factor, a major factor, or not applicable, for your lack of participation in the RPC.

Answered: 24 Skipped: 4

	Not at all a factor	Minor factor	Major factor	Not applicable	Total	Average Rating
RPC goals and objectives are not clear to me	50.00% 12	16.67% 4	8.33% 2	25.00% 6	24	1.00
RPC goals and objectives are not a priority to me or my organization	37.50% 9	25.00% 6	8.33% 2	29.17% 7	24	1.00
I do not know how to apply, or I missed the deadline for applying	45.83% 11	4.17% 1	8.33% 2	41.67% 10	24	1.00
RPC activities do not affect my primary constituency	33.33% 8	12.50% 3	20.83% 5	33.33% 8	24	1.00
Working on the RPC doesn't get me or my organization enough public recognition	58.33% 14	4.17% 1	4.17% 1	33.33% 8	24	1.00
My skills and time would not be well-used	41.67% 10	12.50% 3	8.33% 2	37.50% 9	24	1.00
The RPC is not taking any meaningful action	50.00% 12	16.67% 4	4.17% 1	29.17% 7	24	1.00
I would be the only voice representing my viewpoint	37.50% 9	12.50% 3	8.33% 2	41.67% 10	24	1.00
The time commitments for RPC meetings and activities are too high	41.67% 10	16.67% 4	8.33% 2	33.33% 8	24	1.00
The RPC is competing with my organization	54.17% 13	8.33% 2	0.00% 0	37.50% 9	24	1.00
There is a conflict of interest between my organization and the work of the RPC	54.17% 13	4.17% 1	8.33% 2	33.33% 8	24	1.00

Q5 In your opinion, does the RPC have sufficient representation from stakeholders in Sacramento County to accomplish the objectives of the RPC?

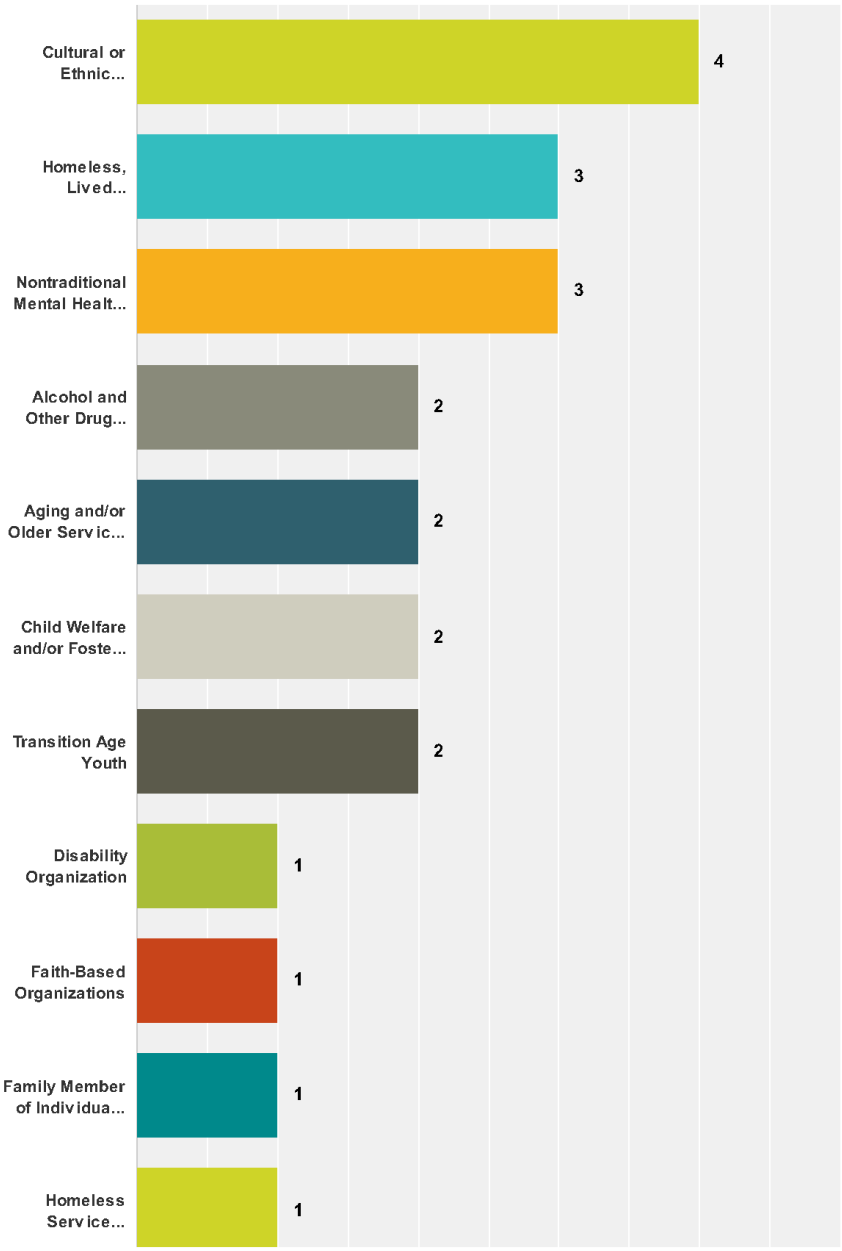
Answered: 25 Skipped: 3



Answer Choices	Responses	
Don't know	64.00%	16
No	24.00%	6
Yes	12.00%	3
Total		25

Q6 If you answered "No" above in your opinion, which type of the following groups, organizations, and/or schools listed are NOT well represented in the RPC? Select all that apply.

Answered: 6 Skipped: 22



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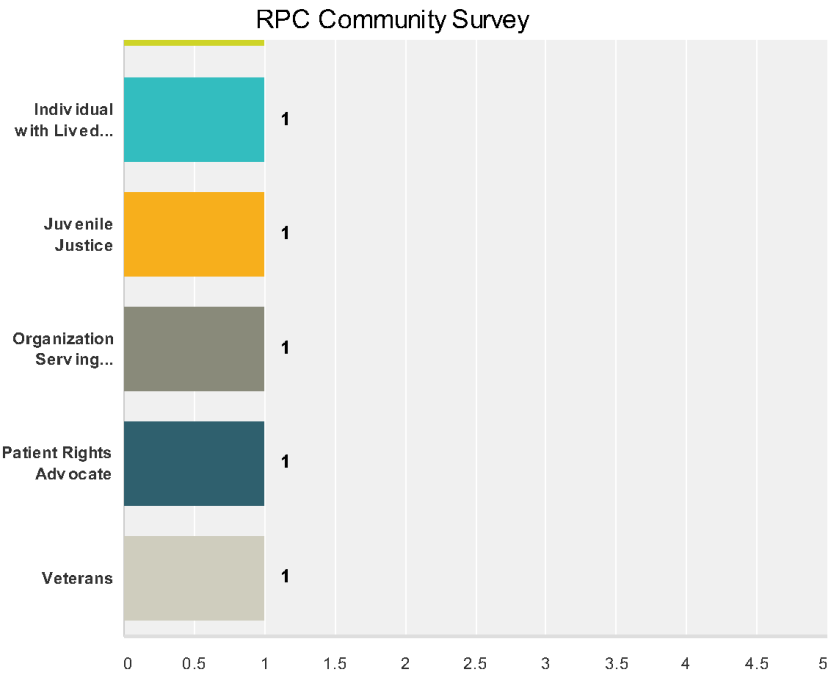


Answer Choices	Responses	
Cultural or Ethnic Community	66.67%	4
Homeless, Lived Experience	50.00%	3
Nontraditional Mental Health Provider inclusive of peer-run services, spiritual healing and alternative medicine	50.00%	3
Alcohol and Other Drug Service Provider	33.33%	2
Aging and/or Older Service Provider	33.33%	2
Child Welfare and/or Foster Care	33.33%	2
Transition Age Youth	33.33%	2
Disability Organization	16.67%	1
Faith-Based Organizations	16.67%	1
Family Member of Individual with Lived Mental Health Experience	16.67%	1
Homeless Service Organization	16.67%	1
Individual with Lived Mental Health Experience	16.67%	1
Juvenile Justice	16.67%	1
Organization Serving Children and Youth	16.67%	1
Patient Rights Advocate	16.67%	1
Veterans	16.67%	1
Total Respondents: 6		

#	Other (please specify)	Date
1	LGBTQQIAA populations	2/5/2014 6:38 PM
2	Those with the most severe mental illnesses and their families	1/22/2014 5:56 PM

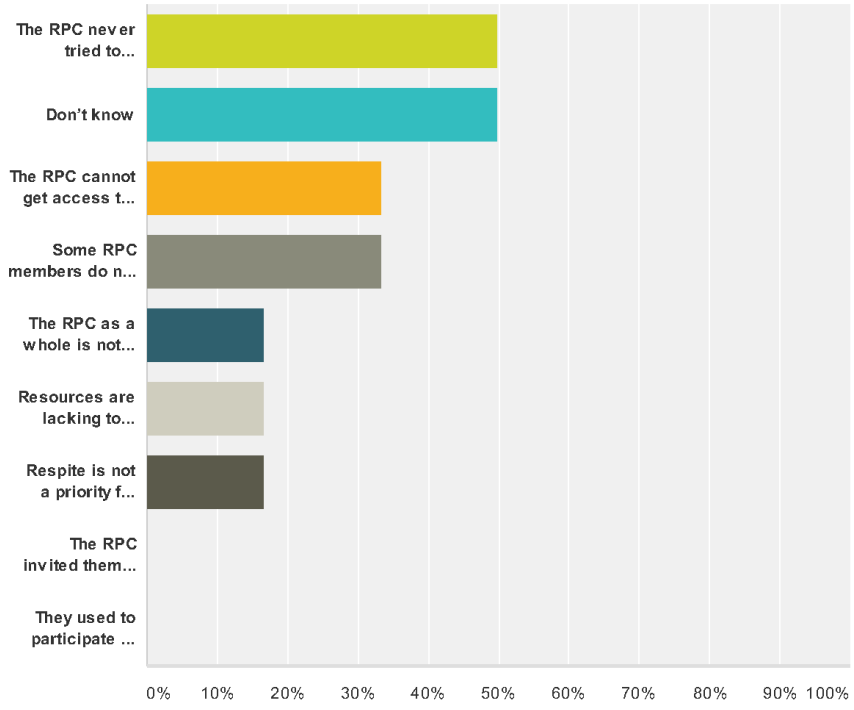
Q7 If you have selected multiple stakeholders above as being not well represented, please select the SINGLE group you think is most important to add to the RPC at this time. Write the name of the group in this box:

Answered: 4 Skipped: 24

#	Responses	Date
1	LGBTQQIAA	2/5/2014 6:38 PM
2	cultural, ethnic, lgbtq communities	1/31/2014 2:20 PM
3	cultural or ethnic community	1/23/2014 11:05 AM
4	Family members of those with smi who lackinsight	1/22/2014 5:56 PM

Q8 Why do you think the stakeholder identified as most important to add to the RPC is not well represented at this time? (Select all that apply)

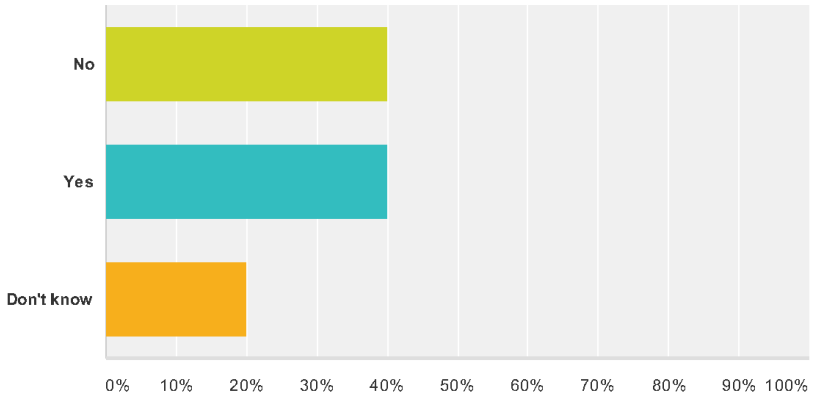
Answered: 6 Skipped: 22



Answer Choices	Responses	
The RPC never tried to involve them	50.00%	3.0
Don't know	50.00%	3.0
The RPC cannot get access to representatives of this group	33.33%	2.0
Some RPC members do not want to share power with this group	33.33%	2.0
The RPC as a whole is not sure that this group should be asked to join	16.67%	1.0
Resources are lacking to recruit new members	16.67%	1.0
Respite is not a priority for this group	16.67%	1.0
The RPC invited them but they chose not to participate	0.00%	0.0
They used to participate but dropped out	0.00%	0.0
Total Respondents: 6		

Q9 Has the RPC helped you learn more about mental health respite care services?

Answered: 25 Skipped: 3



Answer Choices	Responses	
No	40.00%	10
Yes	40.00%	10
Don't know	20.00%	5
Total		25

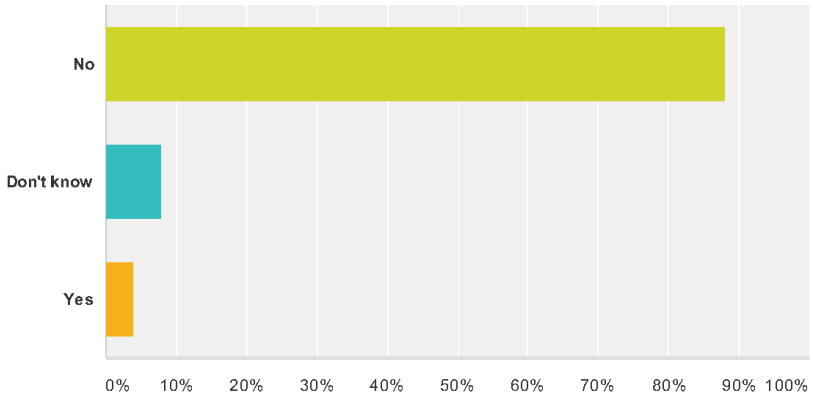
Q10 How do you define mental health respite care services? What kinds of services, from your perspective, fall under the heading of respite care?

Answered: 14 Skipped: 14

#	Responses	Date
1	to care for the elderly in a good way	2/7/2014 9:56 AM
2	Outpatient community services to prevent individuals from ending up with severe mental illness	2/5/2014 6:39 PM
3	temporary residential care for a dependent that provides relief for a caregiver	1/31/2014 3:55 PM
4	A break for for family members from their loved one and a place for individuals with mental health challenges to rest, regroup, and plan for their recovery.	1/31/2014 12:53 PM
5	Housing, Outpatient provider linkage, financial support	1/27/2014 12:52 PM
6	Care services for mentally ill people so that their promary caregivers can have a much-needed break and renew their own energy and motivation to continue to care for their charges.	1/27/2014 8:22 AM
7	A client needs a place to stay briefly due to mental health challenges - like taking a break from family if they live at home. These services are not for the homeless or for someone who needs a longer -term placement	1/26/2014 4:27 PM
8	Crisis intervention, temporary housing, caregiver support groups and crisis intervention, day programs	1/23/2014 12:48 PM
9	Access to safe environments, allowing client the ability to remove themselves from immediate stressors and providing access to services enabling client to improve their position	1/23/2014 10:56 AM
10	crisis respite care, both for consumer and/or caregiver.	1/23/2014 8:10 AM
11	Bridging the gap between a 72 hour facility, an emergency room, and doing nothing.	1/23/2014 7:11 AM
12	Services that provide both the individual and their stakeholders a reprieve from the issues and stress faced dealing with life needs. Everything is needed. I developed and managed both mental and developmental respite programs in Napa County. I also am a founding member of Napa County's Elder Abuse Task Force and a past Mental Health Board Chair for Napa.	1/22/2014 7:44 PM
13	Providing temporary shelter to prevent a crisis from becoming severe enough for hospitalization.	1/22/2014 5:57 PM
14	Services to help a wide range of citizens of all ages, from very young to very old, for the purpose of preventing a crisis.	1/22/2014 5:35 PM

Q11 Have you ever applied for funding from the RPC?

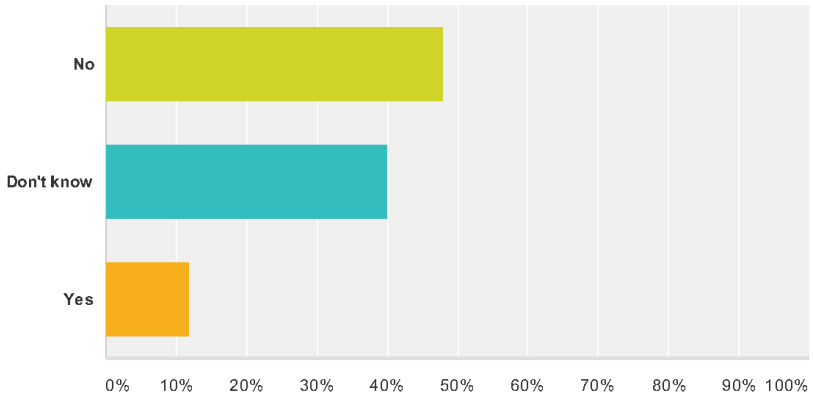
Answered: 25 Skipped: 3



Answer Choices	Responses	
No	88.00%	22
Don't know	8.00%	2
Yes	4.00%	1
Total		25

Q12 Do you intend to apply for funding from the RPC in the future?

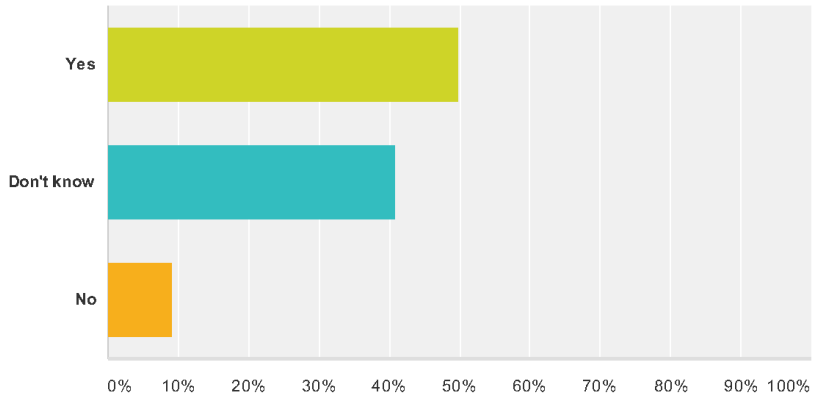
Answered: 25 Skipped: 3



Answer Choices	Responses	
No	48.00%	12
Don't know	40.00%	10
Yes	12.00%	3
Total		25

Q13 Has the RPC been responsible for any activities or programs that otherwise would not have occurred?

Answered: 22 Skipped: 6



Answer Choices	Responses	
Yes	50.00%	11
Don't know	40.91%	9
No	9.09%	2
Total		22

Q14 Please select how much you agree or disagree with the following statements.

Answered: 22 Skipped: 6

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total	Average Rating
The RPC is making progress in implementing the activities that have potential to improve respite services	0.00% 0	9.09% 2	36.36% 8	22.73% 5	31.82% 7	22	1.00
The RPC is improving mental health outcomes for people at risk of experiencing crises	0.00% 0	9.09% 2	40.91% 9	13.64% 3	36.36% 8	22	1.00
The RPC is essential to the improvement of respite care services in Sacramento County	0.00% 0	4.55% 1	40.91% 9	18.18% 4	36.36% 8	22	1.00
One or a small number of people or agencies could make significant progress in respite care services without the RPC	4.55% 1	22.73% 5	22.73% 5	9.09% 2	40.91% 9	22	1.00

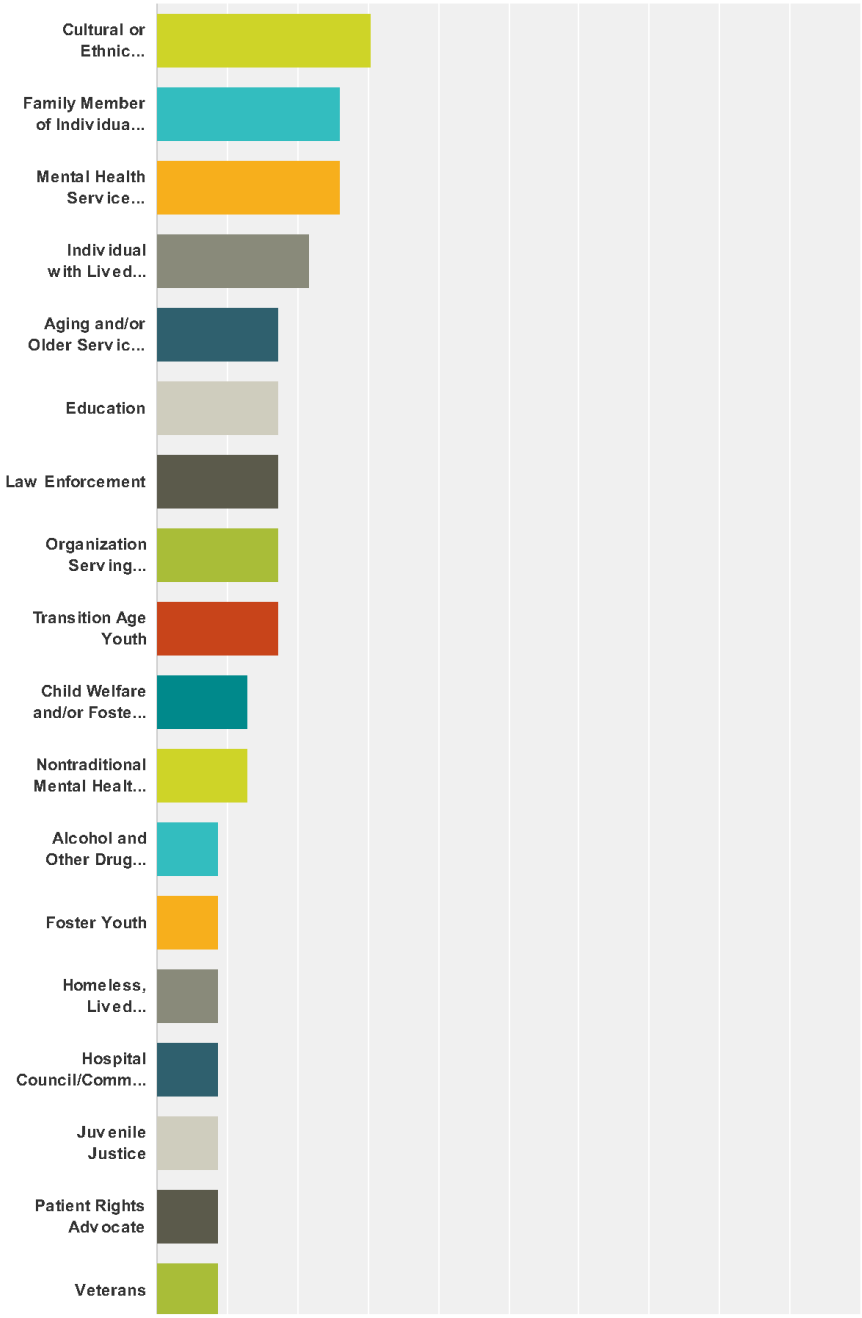
Q15 What issues should the RPC be paying more attention to?

Answered: 9 Skipped: 19

#	Responses	Date
1	chronic substance abuse	2/12/2014 10:53 AM
2	Continued support for underserved communities	2/5/2014 6:40 PM
3	Improved education on recovery resources for consumers.	1/31/2014 12:54 PM
4	Care for the very old clients and their caregivers	1/27/2014 8:24 AM
5	Informing others about what they do!	1/26/2014 4:27 PM
6	n/a	1/23/2014 8:11 AM
7	Behavioral management for family and individual. Assisting them to recognize behavioral triggers and develop appropraite interventions or replacement behaviors. Mentorships and WRAP teaching. Working with individuals where they are at in their recovery.	1/22/2014 7:48 PM
8	homeless youth showing symptoms of smi	1/22/2014 5:58 PM
9	Extremely vulnerable persons, including very old persons	1/22/2014 5:36 PM

Q16 Please indicate the stakeholder perspectives you represent. Select all that apply.

Answered: 23 Skipped: 5



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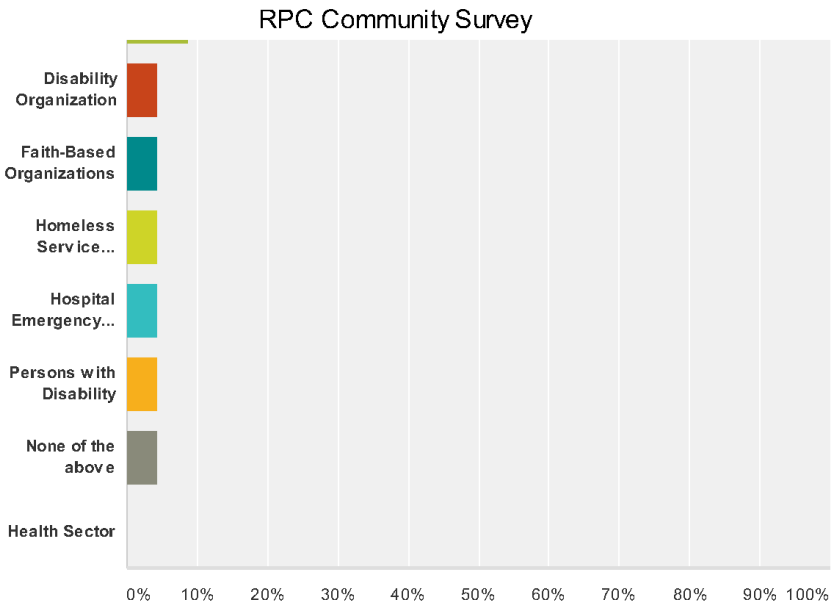


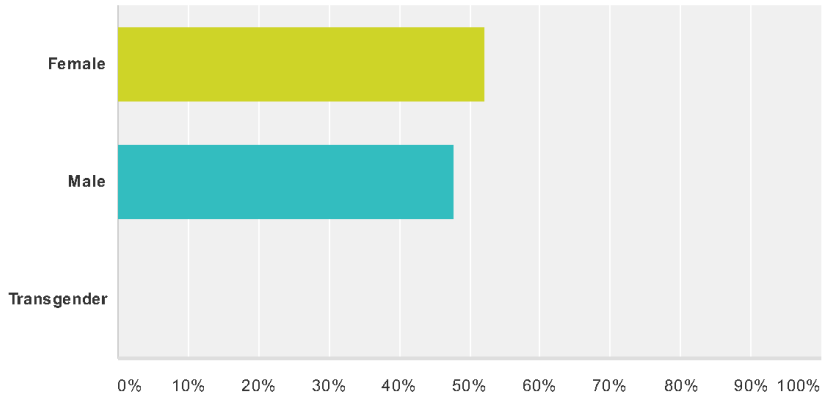
Answer Choices	Responses	
Cultural or Ethnic Community	30.43%	7
Family Member of Individual with Lived Mental Health Experience	26.09%	6
Mental Health Service Provider Association	26.09%	6
Individual with Lived Mental Health Experience	21.74%	5
Aging and/or Older Service Provider	17.39%	4
Education	17.39%	4
Law Enforcement	17.39%	4
Organization Serving Children and Youth	17.39%	4
Transition Age Youth	17.39%	4
Child Welfare and/or Foster Care	13.04%	3
Nontraditional Mental Health Provider inclusive of peer-run services, spiritual healing and alternative medicine	13.04%	3
Alcohol and Other Drug Service Provider	8.70%	2
Foster Youth	8.70%	2
Homeless, Lived Experience	8.70%	2
Hospital Council/Community Mental Health Partnership	8.70%	2
Juvenile Justice	8.70%	2
Patient Rights Advocate	8.70%	2
Veterans	8.70%	2
Disability Organization	4.35%	1

Faith-Based Organizations	**4.35%**	1
Homeless Service Organization	**4.35%**	1
Hospital Emergency Department	**4.35%**	1
Persons with Disability	**4.35%**	1
None of the above	**4.35%**	1
Health Sector	**0.00%**	0
Total Respondents: 23		

#	Other (please specify)	Date
1	LGBTQQIAA	2/5/2014 6:40 PM
2	Supported employment services	1/31/2014 12:55 PM
3	Alcohol and Drug Services Administration	1/27/2014 8:25 AM

Q17 Your gender:

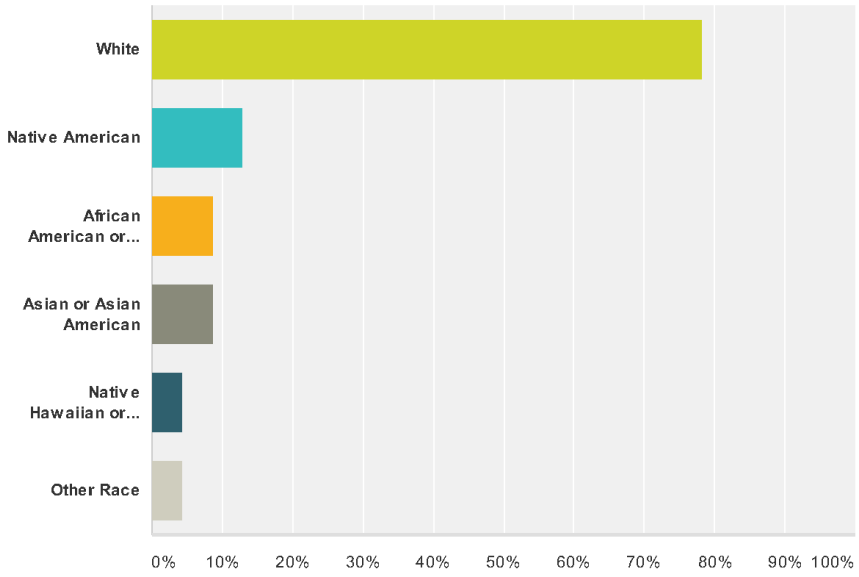
Answered: 23 Skipped: 5



Answer Choices	Responses	
Female	**52.17%**	12
Male	**47.83%**	11
Transgender	**0.00%**	0
Total		**23**

Q18 Your race: (Choose all that apply)

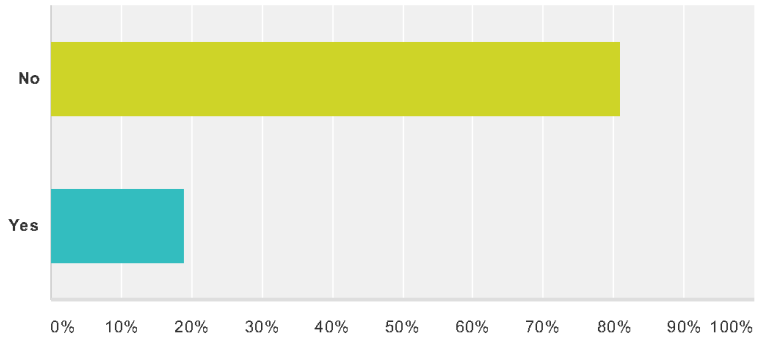
Answered: 23 Skipped: 5



Answer Choices	Responses	
White	**78.26%**	18
Native American	**13.04%**	3
African American or Black	**8.70%**	2
Asian or Asian American	**8.70%**	2
Native Hawaiian or other Pacific Islander	**4.35%**	1
Other Race	**4.35%**	1
Total Respondents: 23		

Q19 Are you Latino or Hispanic?

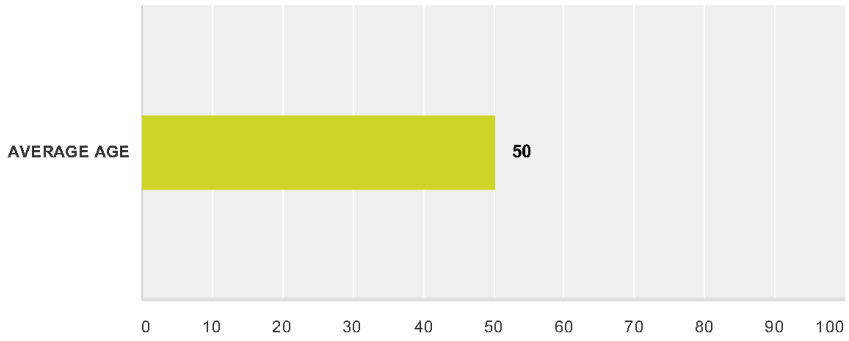
Answered: 21 Skipped: 7



Answer Choices	Responses	
No	80.95%	17
Yes	19.05%	4
Total		21

Q20 Your age at last birthday

Answered: 22 Skipped: 6



#	AGE	Date
1	35	2/12/2014 10:55 AM
2	62	2/10/2014 3:12 PM
3	25	2/5/2014 6:40 PM
4	45	2/5/2014 2:23 PM
5	46	2/3/2014 9:07 AM
6	67	2/2/2014 6:26 AM
7	62	1/31/2014 3:55 PM
8	56	1/31/2014 2:22 PM
9	55	1/31/2014 1:48 PM
10	61	1/31/2014 12:55 PM
11	45	1/28/2014 2:08 PM
12	60	1/27/2014 8:25 AM
13	35	1/26/2014 4:28 PM
14	49	1/23/2014 12:49 PM
15	56	1/23/2014 11:09 AM
16	46	1/23/2014 10:57 AM
17	37	1/23/2014 8:12 AM
18	48	1/23/2014 7:12 AM
19	47	1/22/2014 8:59 PM
20	60	1/22/2014 7:49 PM
21	55	1/22/2014 5:59 PM
22	53	1/22/2014 5:37 PM

Appendix E. RPC Charter

Respite Partnership Collaborative Charter

BACKGROUND

The Respite Partnership Collaborative (RPC) is a public-private partnership of the County of Sacramento Division of Behavioral Health Services and Sierra Health Foundation: Center for Health Program Management (the Center). The RPC is funded through the Sacramento County Mental Health Services Act (MHSA) Innovation Component. MHSA, also known as Proposition 63, was passed by voters in 2004 to provide funding to help counties transform mental health services across all age groups and address a broad continuum of prevention, early intervention, treatment and recovery needs. The MHSA Innovation Component allows counties to try different approaches and practices to identify what may work to increase access for underserved communities, promote interagency collaborations and increase access to services.

Formed in May 2012, the RPC is a collaborative in which members are engaged in a community-driven process committed to implementing the Sacramento County MHSA Innovation Plan. In part, the learning objective for this innovation project is to increase voluntary community-based local mental health respite service options to offer a variety of alternatives to psychiatric hospitalization for community members experiencing a crisis in Sacramento County. It is doing this by providing time-limited funding for the sole purpose of developing and trying out new respite practices and/or approaches. RPC members are volunteers who represent a diverse cross-section of interests related to respite care for those with a mental illness and their family members in Sacramento County.

Using the Sacramento County MHSA Innovation Plan as the blueprint, the RPC has designed a process to encourage the community to develop different approaches to respite care, and apply for funding support to put these options into practice. In November 2012, the RPC released the first of three funding rounds to four Sacramento County organizations that met the criteria for mental health respite services. Additional rounds of funding will support the continuum of respite options.

PROJECT ADMINISTRATION AND SPONSORS

Sierra Health Foundation: Center for Health Program Management

Sierra Health Foundation: Center for Health Program Management's (CHPM) mission is to serve a leadership role in expanding health and wellness in California. The Center's growing expertise in program management, measurement/assessment and communications is designed to elevate the efficiency, reach and impact of the projects and programs it manages. The Center was established in recognition of a statewide need for increased community capacity to engage in the planning, implementation and assessment of efforts that seek to address health needs of the underserved. The Center is positioned as a catalyst for population health interventions that address health equity, health determinants and health access by providing a broad range of

operational support to projects that require effective collaboration among public and private funders, foundations and communities**.**

The Center was selected by the County of Sacramento to administer the RPC. MHSA Innovation funding supports the RPC recommendations to fund respite service grants to community organizations.

County of Sacramento Division of Behavioral Health Services (DBHS)

DBHS offers behavioral health services to Sacramento County residents by providing alcohol and drug treatment services, specialty mental health services and assistance for individuals unable to care for their personal needs or financial resources. The mission of DBHS is to provide a culturally competent system of care that promotes holistic recovery, optimum health and resiliency. DBHS recognizes that Sacramento County is one of the most ethnically and racially diverse counties in California and appreciates differences and understands the importance of embedding cultural competence in all areas including operation, policies and structures to be responsive to the changing dynamics of our community and ensure high-quality services.

VISION

The RPC seeks to make impact by working together to follow the Sacramento County MHSA Innovation plan and create alternatives to emergency rooms, hospitals and out-of-home care for those at-risk of and in a mental health crisis. We will stimulate valuable services for mental health consumers, families and caregivers, especially for those of us that fall through the cracks. We will strive to create a funding process that attracts the strongest respite partners to provide services to meet the greatest needs. We will work to inspire other communities. We will work to have our efforts integrated into other programs. We will grow awareness in order to attract resources to sustain this work.

MISSION

The RPC seeks to address mental health crisis by establishing respite options to help reduce the need for hospitalizations that could occur as a result of mental health crisis. The RPC will accomplish this through providing up to three funding rounds through 2015. This funding will support mental health respite programs in Sacramento County that includes wellness and recovery principles, peer/youth/family/caregiver support services, and are located in neighborhood or home-like settings. These respite services will serve, at a minimum, the following populations: 1) Children with complex mental health needs in crisis–parents/caregivers who need a break, 2) Specialized or cultural or ethnic populations, 3) Teens/transition age youth (16-24), 4) Adults/older adults in crisis, and 5) Adults in crisis who have dependent children.

ROLES & RESPONSIBILITIES

The RPC works collaboratively to:

1. Make recommendations about RPC membership and governance structure
2. Participate in RPC monthly meetings and ongoing standing committee meetings, attend quarterly RPC events and represent the RPC at community stakeholder meetings
3. Define and recommend funding for new and existing respite services using innovative approaches as outlined in the Sacramento County MHSA Innovation Plan
4. Participate in the respite program selection process
5. Participate in RPC project evaluation

6. Establish partnership and networking opportunities with other community resources and MHSA programs
7. Explore options for leveraging and sustaining crisis respite
8. Develop technology to identify and track respite options in Sacramento County

Sierra Health Foundation: Center for Health Program Management (the Center) will:

1. Coordinate and partner with DBHS to implement the Innovation Plan
2. Establish the RPC
3. Host/coordinate and participate in RPC and community meetings
4. Facilitate the Respite Program selection process
5. Oversee and manage funding awards
6. Develop and implement evaluation activities to assess progress on learning goals, provide data to RPC, DBHS, and community
7. Develop and implement a communication plan (to engage community, share learning, provide information on respite and funding opportunities)

The Sacramento County Division of Behavioral Health Services will:

1. Coordinate/partner with the Center to implement the Innovation Plan
2. Develop criteria for the RPC based on the Innovation Plan
3. Provide liaison and technical assistance to the Center and RPC, and facilitate connections to other Mental Health Services Act programs
4. Participate in the RPC to provide mental health content expertise
5. Partner with the Center to develop an evaluation framework
6. Monitor the contract with the Center
7. Report results to Department of Mental Health and Oversight and Accountability Commission

Facilitator(s) will:

1. Provide consultation and neutral, third party leadership to the process.
2. Develop the agenda, desired goals and processes for RPC meetings in consultation with staff and stakeholders.
3. Manage meetings and work with members to enforce ground rules.
4. Assist in building consensus; for example, by summarizing decisions, agreements and areas where issues remain unresolved.
5. Serve as a confidential communication channel for participants who wish to express views privately because they do not feel comfortable doing so in public.
6. Advocate for a fair, effective and credible process but remain impartial with respect to the outcome of funding or other decisions.

Stakeholders/Community Members will:

1. Share expertise and contribute ideas to the Respite Partnership Collaborative.
2. Adhere to the same ground rules as RPC members when attending RPC meetings or community forums.

MEMBERSHIP POLICY

Respite Partnership Collaborative members are volunteers who have a commitment to implement the MHSA Innovation Plan. These volunteers represent a diverse cross-section of interests related to respite care for the mentally ill and their family members in Sacramento County (see Sacramento County MHSA Innovation Plan, Attachment A).

1. The RPC will consist of 25 members.
2. Interested persons shall apply as individuals, not as representatives of a particular organization.
3. Members will be drawn from:
    - Consumers, family members of consumers and representatives of the five populations to be served:
        - Children with complex mental health needs – parents need a break
        - Specialized or cultural or ethnic population
        - Teens/transition age youth (TAY) in crisis
        - Adults/older adults in crisis
        - Adults in crisis who have dependent children
    - Mental health agencies, nontraditional mental health providers, homeless programs, faith-based providers, system partners, cultural brokers/representatives, advocates and other respite/mental health experts, among others. A system partner refers to representation from other systems. Examples of system partners include but are not limited to representation from Child Protective Services and/or the Hospital Council.
    - The RPC has determined that there is an urgency to fill existing gaps in membership that have been identified as
    - Law Enforcement
    - Transitional Age Youth (TAY)/Youth

- Homeless
- Cultural/Ethnic Communities
- Lesbian, Gay Bisexual, Transgender and Questioning Community
- Hospital Emergency Department representation, which could include crisis response teams, mobile crisis and/or targeted case managers working with children with complex mental health needs
- Veterans

4. Membership is by application, including references, following procedures set up by the Governance and Membership Committee.
5. Members shall commit the time and applicable resources, e.g., contacts, knowledge and experience, not only in respite/mental health but in growing the collaborative, to the RPC work.
    - Current members can extend their membership to an additional one-year term.
        - Current members are required to serve on at least one of the four standing committees.
        - Current members who require an exception to serving on a standing committee are encouraged to discuss their need with the Governance and Membership Committee.
        - The Conflict of Interest Policy applies to all standing committee participation.
    - New members brought on in 2013 shall commit to a two-year term, which is renewable for a second two-year term.
        - New members shall be required to serve on one of the designated standing committees as indicated by the applicant during the application process.
        - The Conflict of Interest Policy applies to all standing committee participation.
6. Members' opinions and participation is a valuable asset to the collaborative. Members are offered this opportunity to contribute by actively participating on a regular basis at RPC meetings. Members may miss up to three RPC meetings and special events in a six-month period. Members who are absent for more than three (3) regularly scheduled RPC meetings or special events within a six-month interval will be asked to discuss their participation with the Governance and Membership Committee.
7. Members shall elect two co-chairs who will collaborate with RPC partners to support the facilitation of the RPC and RPC meetings. Co-chair terms will be for one year. One co-chair shall have lived experience with mental illness. Other criteria for selection as co-chair is as follows:
    - Must demonstrate good attendance as defined in the RPC Membership Policy
    - Must be able to attend and participate in RPC planning meetings
    - Must be able and/or willing to take a leadership role in RPC meetings
8. Members shall contact the Sierra Health Foundation: Center for Health Program Management Program Officer by the meeting RSVP deadline when they expect to be absent from a meeting. Members are encouraged to stay engaged and connected by contacting one of the RPC co-chairs and/or their committee chair to learn more about the missed meeting.
9. Alternates. Only under special circumstance will alternates be allowed. Requests for an exception to this rule are to be made, in writing, to the Governance and Membership Committee.

STANDING COMMITTEE STRUCTURE AND DESCRIPTIONS

The RPC established four standing committees in spring 2013, and each RPC member is required to participate in at least one. RPC members who require an exception are encouraged to discuss their need with the Governance and Membership Committee. RPC standing committees are strongly encouraged to recruit additional community members to participate.
The RPC Conflict of Interest Policy applies to RPC and community members' committee participation.
Committee terms are for a minimum of one year and up to two years. Each committee is supported by one RPC standing committee chair with additional support from the Center staff. Committee chairs, or their designated substitute, report on committee progress and decisions to the RPC. Each committee selects its own chair and determines its meeting days and times.
RPC committees, standing and/or ad hoc, are bound by the RPC Charter. A committee may make decisions relevant to the responsibilities of their scope of work but may not override the decisions and guidance of the RPC. Committees will seek consensus in their decisions. If unable to reach consensus, the chair will bring the range of opinions to the full RPC for deliberation.

1. **Governance and Membership Committee**
    a. Review RPC governance issues and provide recommendations to be brought forth to the RPC.
    b. Oversee membership recruitment including soliciting and reviewing applications, selecting new members and developing a process for orienting new RPC members.
    c. Identify missing member stakeholder perspectives on the RPC and actively recruit those stakeholders as RPC members.
    d. Consider special requests/exceptions with respect to appointing alternates and oversee membership rules.
    e. Work with partners to identify ways to facilitate participation of members via technology.
2. **Communication Committee**
    a. Develop and implement a marketing and communication plan, including the use of social media. The plan(s) will include specific approaches to reach the groups identified in the MSHA Innovation Plan as well as the larger Sacramento community.
    b. Develop and implement a communications strategy that will take a multi-pronged approach in order to promote the concept of respite throughout Sacramento County, the RPC and the public-private partnership, and respite services funded through the MHSA Innovation project.
    c. In conjunction with the Governance and Membership Committee, plan events to present selected proposals to the community.
3. **Grantmaking and Evaluation Committee**
    a. Develop Requests for Proposals following the guidelines agreed to by the RPC.
    b. Review submitted proposals and present selected proposals to the RPC for final recommendation to the Center and DBHS for vetting.
    c. Work with the Center and DBHS to take questions raised by the RPC back to the candidates for resolution.
    d. Communicate with internal and external evaluators.
    e. Work with the Center and external evaluators on grantee evaluation activities.

f. Establish protocol for working with grantees to maximize the success of their projects.

g. Develop technology to identify and track respite options in Sacramento County.

4. Sustainability, Public Policy and Collaboration Committee

a. Create a sustainability plan that includes a strong public policy approach.

b. Strengthen collaboration with traditional partners and establish connections with non-traditional partners.

c. Establish partnership and networking opportunities with other community resources and MHSA programs.

d. Engage RPC members in the implementation of the sustainability plan to ensure that the RPC can continue its work beyond the initial funding period.

e. Identify potential funding and leveraging opportunities.

f. Work in collaboration with RPC partners to plan and host community stakeholder meetings.

DECISIONMAKING PROCESS

1. Consensus as the Fundamental Principle

Working toward consensus is a fundamental principle of the RPC, based on principles of "consensus with accountability." Consensus with accountability requires all participants to try to reach consensus while at the same time supporting and expressing their stakeholder group's interest. Working toward consensus is a collaborative process with everyone contributing to shape a proposal into a decision that meets the concerns of all group members as much as possible.

2. Definition of "Consensus"

A decision that all group members can live with, reached by the group as a whole. Members may hold different levels of agreement. In reaching consensus, some members may strongly endorse a proposal while others may accept it as "workable." Others may only be able to "live with it." Others may choose to "stand aside" by verbally noting a disagreement, yet allowing the group to reach a consensus without them. Any of these still constitutes consensus. The decision may not be everyone's first or ideal choice, but there is common understanding and a commitment to move forward together. Straw polls may be used to assess the degree of preliminary support for an idea.

When the group reaches consensus on an issue, ideally each member can honestly say:

- I believe that other members understand my stakeholder group's point of view,
- I believe I understand other members' stakeholder group's points of view, and
- Whether or not I prefer this decision, I support it because it was arrived at openly and fairly, and it is the best solution for us at this time.

3. Divergent Views/Unresolved Issues, i.e., No Consensus

When rejecting a proposal, the member must provide a counter proposal that legitimately attempts to achieve consensus and put forth what is in the best interest of the RPC. If the full group is still unable to reach consensus, a proposal may move forward if supported by 75% of the members present. Alternatively, if time allows, members may delegate the issue to a standing or ad hoc committee for further deliberation, information gathering and problem solving.

4. Participation

Members must be in attendance at a meeting to participate in decisions made at that meeting. If a member cannot attend a meeting where a key decision is planned they may send an email to express

their stakeholder viewpoint to the entire collaborative (including partners and staff) in advance of the meeting.

5. **Administrative Decisions**

   Administrative decisions, such as meeting scheduling or an agenda item, will be obtained by a simple majority as needed. Administrative decisions will take into consideration potential limitations influencing logistics; for example, availability of meeting space.

6. **Committee Decision Making**

   RPC committees are bound by the RPC charter. Committees may make decisions relevant to the responsibilities of their scope of work but may not override the decisions and guidance of the entire RPC. Committees will seek consensus in their decisions. If unable to reach consensus, they will bring the range of opinions to the full RPC for deliberation. Each standing committee will select its own committee chair and report on progress and decisions to the full RPC.

GROUND RULES

Ground Rules: A tool facilitator and group members use to enlist peoples' best conduct in meetings. Ground rules:

1. Create a foundation for respectful dialogue
2. Provide guidelines for how the group will work together
3. Are agreed to by all RPC members

- **Use Common Conversational Courtesy:** One person talks at a time; group members listen respectfully, refrain from interrupting and refrain from side conversations.
- **Each Contributes & "Shares the Air":** All group members are responsible for a meeting's success and outcomes and support the facilitator in doing his/her job. No one dominates; all participate in assuring the ground rules are observed.
- **Value All Ideas and Perspectives:** Welcome new ideas, seek to understand and view disagreements as problems to be solved rather than battles to be won.
- **Assume Good Will:** Give others the benefit of the doubt when considering their intentions. We're all here because we care and are trying to do our best.
- **Honor Time:** Stay on subject, be concise and use the "parking lot" for additional items.
- **Have Fun:** Humor is welcome but never at someone else's expense
- **Silence Electronics**
- **Spelling Doesn't Count**
- **Use the Microphone When Speaking**

MEETINGS

The RPC meets regularly at Sierra Health Foundation. The meetings are open to the public; however, a limited number of guest seats are available and must be reserved at least one week before each meeting on a first-come, first-served basis. A meeting schedule, meeting documents, a public registration form and other materials are posted on the RPC web page at www.sierrahealth.org/rpc**.**

COMMUNICATION PROCESS

Notes and associated documents from each RPC meeting will be posted on the RPC web page as soon as feasible. RPC members serve as conduits for two-way information exchange with their constituencies. Members are asked to keep their constituents informed about the process and to bring constituents' views into the discussion. Constituents who want to provide input are encouraged to share their suggestions with RPC members.

CHANGES TO CHARTER

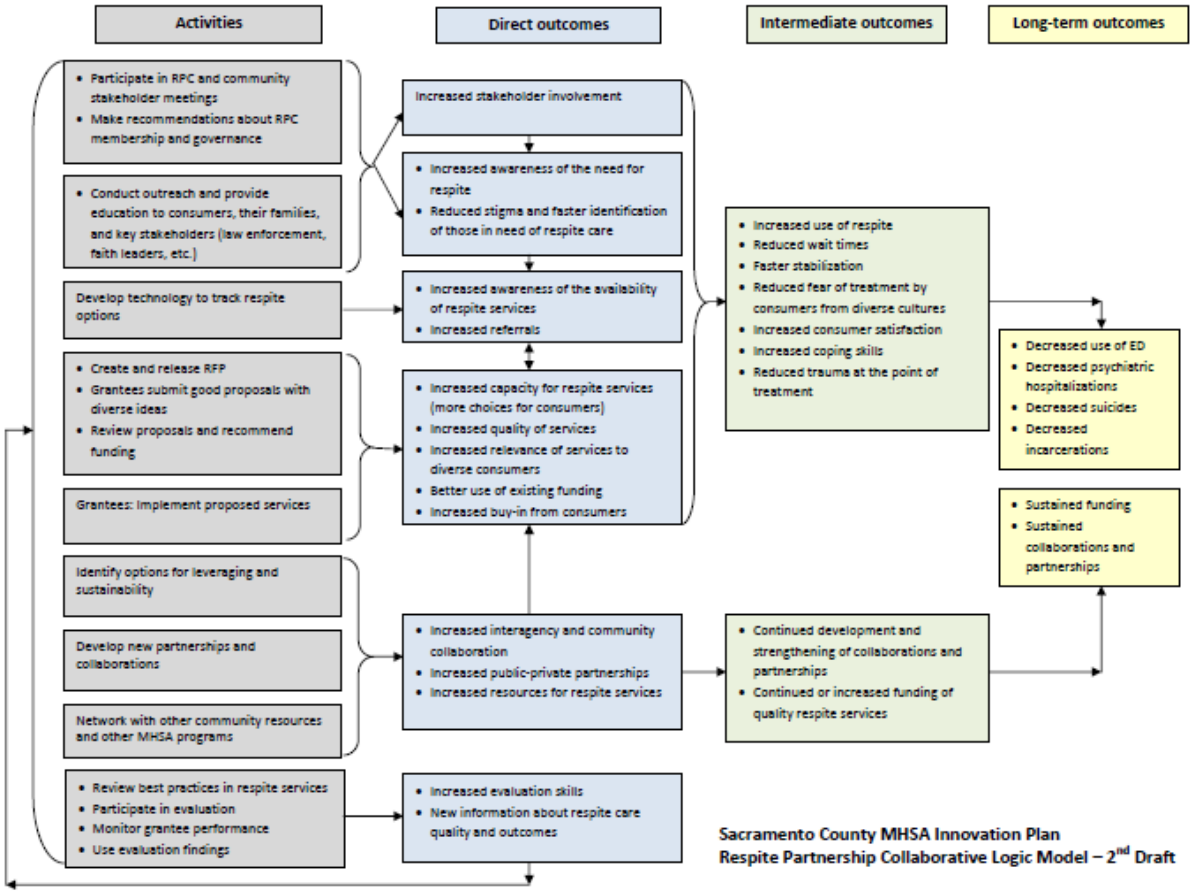
As the project evolves, the RPC may use its decision making procedure, identified above, to adopt changes to this Charter.

REFERENCE DOCUMENTS

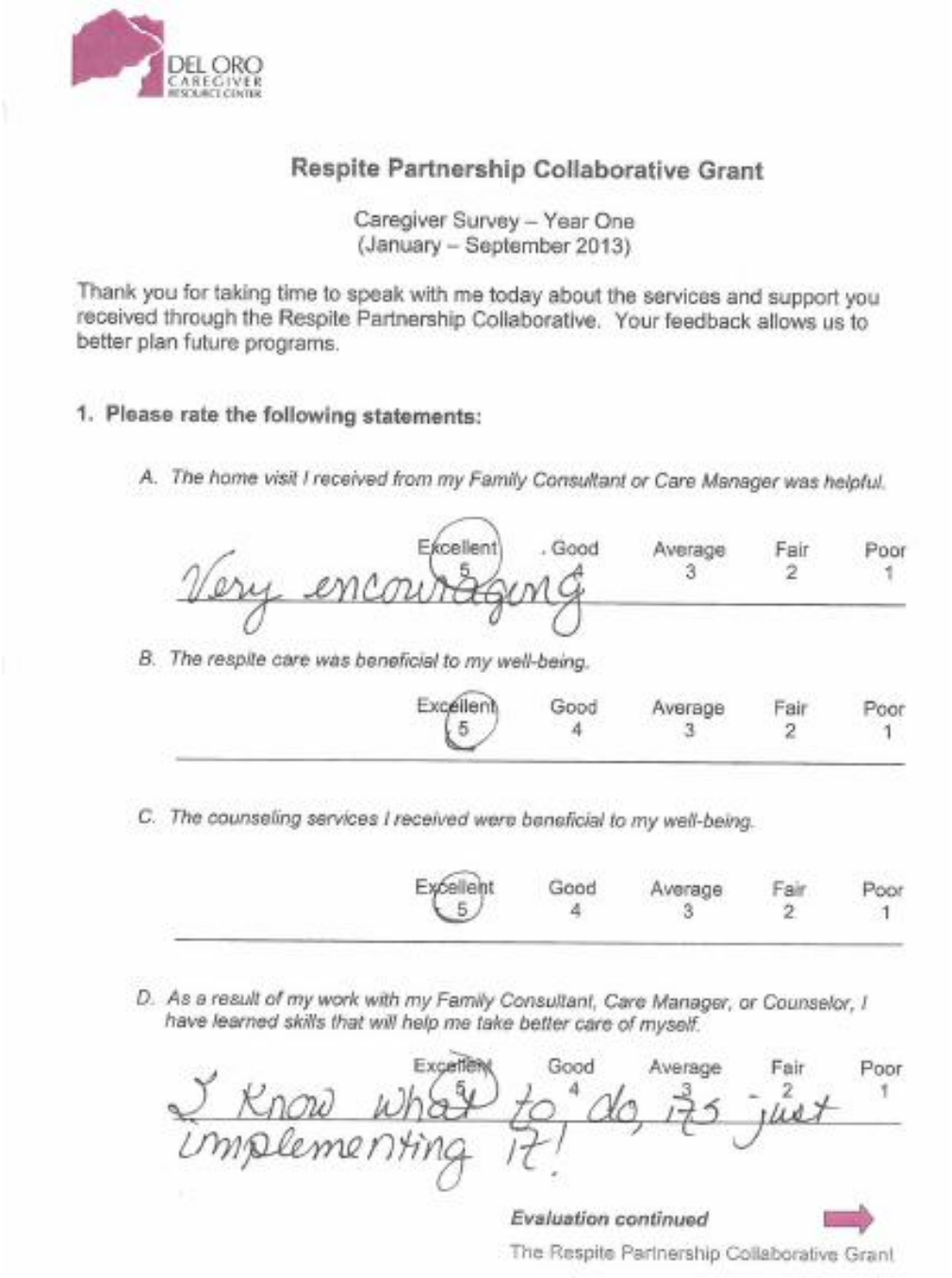
- **RPC Membership Roster** http://www.sierrahealth.org/assets/RPC_Member_List_June_2013.pdf
- **RPC Meeting Schedule**

  http://www.sierrahealth.org/doc.aspx?303
- **Innovation Plan Attachment A**
  http://www.sierrahealth.org/assets/Innovation_Plan_Attachment_A_2011.pdf
- **Sacramento County MHSA Steering Committee Vision, Mission and Values**
  http://www.dhhs.saccounty.net/BHS/Documents/Advisory-Boards-Committees/Mental-Health-Services-Act-Committee/MHSA-Vision-Mission-Values.pdf

Appendix F. Logic Model



Appendix G. Del Oro Survey



DEL ORO CAREGIVER RESOURCE CENTER

Respite Partnership Collaborative Grant

Caregiver Survey – Year One
(January – September 2013)

Thank you for taking time to speak with me today about the services and support you received through the Respite Partnership Collaborative. Your feedback allows us to better plan future programs.

1. Please rate the following statements:

A. *The home visit I received from my Family Consultant or Care Manager was helpful.*

Excellent 5 . Good 4 Average 3 Fair 2 Poor 1

Very encouraging

B. *The respite care was beneficial to my well-being.*

Excellent 5 Good 4 Average 3 Fair 2 Poor 1

C. *The counseling services I received were beneficial to my well-being.*

Excellent 5 Good 4 Average 3 Fair 2 Poor 1

D. *As a result of my work with my Family Consultant, Care Manager, or Counselor, I have learned skills that will help me take better care of myself.*

Excellent 5 Good 4 Average 3 Fair 2 Poor 1

I know what to do, it's just implementing it!

Evaluation continued

The Respite Partnership Collaborative Grant

E. *The services and support I have received have improved my outlook on my caregiving situation.*

Excellent 5 Good 4 Average 3 Fair 2 Poor 1

Hope for future, less resentment.

2. What did you find most helpful, useful and/or enjoyable?

Comments: time to myself.

3. How could we improve upon the services and support you received through this grant?

Comments: N/A

Thank you for your time and commitment to this program!

Appendix H. Turning Point Community Programs Survey

Turning Point Community Programs
CONSUMER SATISFACTION SURVEY

Client Name: _____

Refused/Unable to Administer: ☐

In order to provide the best possible mental health services, we need to know what you think about the services you received during the last 6 months, the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers. Please indicate your agreement/ disagreement with each of the following statements by circling the number that best represents your opinion. If the question is about something you have not experienced, circle the number 9 to indicate that this item is "not applicable" to you.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. I like the services that I received here.	1	2	3	4	5	9
2. If I had other choices, I would still get services from this agency.	1	2	3	4	5	9
3. I would recommend this agency to a friend or family member.	1	2	3	4	5	9
4. The location of services was convenient (parking, public transportation, distance, etc.).	1	2	3	4	5	9
5. Staff were willing to see me as often as I felt it was necessary.	1	2	3	4	5	9
6. Staff returned my call in 24 hours.	1	2	3	4	5	9
7. Services were available at times that were good for me.	1	2	3	4	5	9
8. I was able to get all the services I thought I needed.	1	2	3	4	5	9
9. I was able to see a psychiatrist when I wanted to.	1	2	3	4	5	9
10. Staff here believe that I can grow, change and recover.	1	2	3	4	5	9
11. I felt comfortable asking questions about my treatment and medication.	1	2	3	4	5	9
12. I felt free to complain.	1	2	3	4	5	9
13. I was given information about my rights.	1	2	3	4	5	9
14. Staff encouraged me to take responsibility for how I live my life.	1	2	3	4	5	9
15. Staff told me what side effects to watch out for.	1	2	3	4	5	9
16. Staff respected my wishes about who is and who is not to be given information about my treatment.	1	2	3	4	5	9
17. I, not staff, decided my treatment goals.	1	2	3	4	5	9
18. Staff were sensitive to my cultural background (race, religion, language, etc.)	1	2	3	4	5	9
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	1	2	3	4	5	9

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
As a Direct Result of Services I received:						
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	1	2	3	4	5	9
21. I deal more effectively with daily problems.	1	2	3	4	5	9
22. I am better able to control my life.	1	2	3	4	5	9
23. I am better able to deal with crisis.	1	2	3	4	5	9
24. I am getting along better with my family.	1	2	3	4	5	9
25. I do better in social situations.	1	2	3	4	5	9
26. I do better in school and/or work.	1	2	3	4	5	9
27. My housing situation has improved.	1	2	3	4	5	9
28. My symptoms are not bothering me as much.	1	2	3	4	5	9
29. I do things that are more meaningful to me.	1	2	3	4	5	9
30. I am better able to take care of my needs.	1	2	3	4	5	9
31 I am better able to handle things when they go wrong.	1	2	3	4	5	9
32. I am better able to do things that I want to do.	1	2	3	4	5	9
33. I am happy with the friendships I have.	1	2	3	4	5	9
34. I have people with whom I can do enjoyable things.	1	2	3	4	5	9
35. I feel I belong in my community.	1	2	3	4	5	9
36. In a crisis, I would have the support I need from family or friends.	1	2	3	4	5	9

This survey was completed by the individual surveyed (consumer)	
This survey was completed by a Turning Point staff member with the knowledge and approval of the individual surveyed.	

_____
Date

Consumer Comments

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LOCATIONS

Domestic

Washington, D.C.

Atlanta, GA

Baltimore, MD

Chapel Hill, NC

Chicago, IL

Columbus, OH

Frederick, MD

Honolulu, HI

Indianapolis, IN

Naperville, IL

New York, NY

Portland, OR

Sacramento, CA

San Mateo, CA

Silver Spring, MD

Waltham, MA

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Honduras

Ivory Coast

Kenya

Liberia

Malawi

Pakistan

South Africa

Zambia

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